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Medication abortion: Implications for abortion care provision in the United States

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Medication Abortion: Implications for Abortion Care Provision in the United States

by

Tracy Ann Weitz

DISSERTATION

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Medication Abortion: Implications for Abortion Care Provision in the United States

by

Tracy Ann Weitz

DEDICATION

This dissertation is dedicated to the health care providers who, despite all odds, continue to provide quality, compassionate abortion care to women who need it. I dream of a day, in the not to distance future, when society as a whole will understand your work as normal health care which promotes the health and well-being of women.

ACKNOWLEDGEMENTS

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- Chapter 12. "Reprinted from *Contraception* 69(1) Weitz, T. A., Foster, A., Ellertson, C., Grossman, D., & Stewart, F. H., "Medical" and "surgical" abortion: rethinking the modifiers, Pages No. 77-78, Copyright (2004), with permission from Elsevier."
- Chapter 13. "Reprinted from *Social Science & Medicine* 56, Joffe, C. & Weitz, T. A., Normalizing the exceptional: incorporating the "abortion pill" into mainstream medicine, Pages No. 2353-2366, Copyright (2003), with permission from Elsevier."
- Chapter 15 "Reprinted from *American Sexuality Magazine [online issue]* (1) available at http://nsrc.sfsu.edu/HTMLArticle.cfm?Article=201&PageID=60&SID=2B9A6BF3307A77DA1465574290FD14ED. Copyright (2003), with permission from the National Sexuality Resource Center (NSRC), Human Sexuality Studies Program, San Francisco State University."

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It is important that I take a moment to reflect on the help and guidance I received over the course of undertaking this dissertation. Without each of these individuals I could not have completed this journey.

First, I would like to thank my dissertation committee who escorted me along the path. Each of these individuals is a role model in how to successfully conduct public sociology. Carole Joffe, PhD, is herself a leader in this field. I learned every day about new ways of thinking about this incredibly complicated issue. Her compassion for the providers on the front lines of the abortion war is present in everything she does. While co-writing with me was not always easy, she managed to survive and my work is the better for our partnership. Our conversations are invaluable. Ruth Malone, PhD, provided a steady hand, always questioning when I would finally say that I had written enough. Her support around exploring social movements and the complexities of qualitative research were needed and appreciated. And finally, I owe an enormous debt of gratitude to my dissertation chair, Carroll Estes, PhD. Carroll never stopped pushing me to explore my work through a theoretical lens and to question the role of social structures in the phenomena I was observing. Her warm hospitality can not be matched and her dining room table will always represent Marx and Gramsci to me.

My friends and family put up with a lot to help me complete this task. There were events I could not attend and many holidays I simple forgot. My mother, Diane Olds, has always been the rock of my support foundation: "I am woman, hear me roar," and for that I am forever grateful. My stepmother Katie Weitz, cooked meals and bought all my excuses. For my siblings Gordon, Mary Sue, Dee Dee, and Mo, I hope the work I do makes the world a safer and more humane place for their children. All children deserve

the love and support they are able to give theirs. And that is the reason I do this work. My father did not survive to see this undertaking completed. I have such sorrow over this reality but know that he knew in his heart that someday I would finish. While I read and wrote, he patched, painted, plumbed, and built. I miss the sound of his table saw even as I write this.

I need to also acknowledge the years of support I received from Anthony Hunter ("t"). Although he is no longer in my life, he was as integral part of the work presented in these pages. He will always have a space in my heart for allowing me to cut into our household security to "go back to school." He opened up our house as the local gathering spot for anxious and confused sociology doctoral students. Special thanks to my close friends, KC, Austin, Paul, and Amy who are "so ready" for me to be finished. They do not know what it is like to travel with me without the extra suitcase full of dissertation reading materials.

I was uniquely blessed with a cohort of graduate student colleagues who were my lifeline during the six years it took me to complete my degree. From the first day we met, we became fast friends. The endless conference calls we had to try to figure out the meaning of "racialization" and "truth(s)" are indelibly etched in my psyche. I am indebted to each of them: Mauro, Alexis, and Rachel.

Much of what is presented in this dissertation was written at a writing retreat spot in Oregon. I am thankful to Karin and Mike for their willingness to let us invade their "cabin," sometimes for weeks on end, including with our new yellow lab puppy, Beaumont. Beau, himself, helped me realize there was a beautiful landscape outside that

needed to be explored. Those Oregon walks helped clear my brain to contemplate yet unexplored avenues of thinking.

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Other UCSF colleagues have been there along the way, pushing me to take the plunge and to finish. Nancy Milliken, MD, A. Eugene Washington, MD, MSc, and George Sawaya, MD, called me "doctor-to-be" from the minute they met me. In a world of hierarchies I always felt my opinion mattered and that I had something to offer to the conversation. Dixie Horning pushed me to apply never letting my excuses get in the way. Diana Taylor, PhD, was a gentle guiding soul at the end of this process, demonstrating enormous support through a willingness to read a 250-page third area exam with almost no notice. She is the type of faculty member I hope I can become, always stepping aside to let someone else grow or stepping up to help someone out.

During the course of this undertaking ANSIRH lost its fearless leader, Felicia H. Stewart, MD, to cancer. Her wisdom, however, lives on. I miss her friendship, her clarity of vision, and her sense of humor. She once told me that if you are willing to do the work that no one else will do, leave the easier work to someone else. Studying abortion is never easy, but it is the right thing to do and women deserve a more sane and rational approach to their health care needs than the current polemic of the abortion war. I only hope I can continue her legacy.

And to the love of my life, Marj Plumb, DrPH, without whom I never would have come to the end of this journey. She challenges me to new heights and makes me feel like I can do anything. Our dinner conversations have become a lifetime of sharing. I now understand the arch of a conversation, and the meaning of coaching. While my gremlins may continue to tell me "you can't do it or you don't deserve it," their cries are drowned out by the strength of her support and her love for me.

Abstract

Medication Abortion: Implications for Abortion Care Provision in the United States

by

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Carroll L. Estes, Ph.D., Chair

Annually over 1.3 million abortions are performed in the US. Despite ongoing need, the number of health care facilities which offer abortion care continues to decline. In 1988 a new abortion technology, mifepristone (aka "RU486" or the "abortion pill") was introduced in France. Use of this drug to induce a miscarriage is generically referred to as a "medication abortion." US availability of mifepristone was expected to result in an increase in providers offering abortion care. Approval in the US, however, was not obtained until 2000 and since then the uptake by non-abortion providing physicians has been slow.

This dissertation explores the implications of medication abortion for abortion care provision in the United States. Section I provides an overall theoretical framework which guides the substantive work. A sociopolitical history of abortion in the United States is presented in Section II. Of importance is the production of a hegemonic understanding of abortion as problematic which continues to shape contemporary understanding of abortion. The centrality of the profession of medicine is traced from

early opposition to abortion in the mid 1800s to efforts to reform and repeal abortion laws in the 1960's. The pro-life and pro-choice social movements are presented in depth.

Section III includes material specifically related to medication abortion. The language used, the uniqueness of the drug within the US health care system, and options for addressing issues of malpractice are included as chapters. The results of two empirical studies are also presented. The first, a small qualitative study of physicians in rural Arkansas illuminates the role of the pharmaceutical companies in practice patterns. This article concludes by recommending that medication abortion be "sold" using the techniques of pharmaceutical detailing. This charge is taken up in the second study presented which used "academic detailing" to take medication abortion to physicians practicing in rural California. The academic detailing technique appears successful at reaching providers who were not yet providing medication abortion but had favorable opinions about abortion, academic detailing, and the need for more abortion services.

CarrollEsh

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INTRODUCTION

Abortion is the most socially contested issue of the modern era. Abortion, however, is more than simply a political issue; it is also a health care service. Annually over 1.3 million abortions are performed in the United States; and one in every five pregnancies ends in abortion (Henshaw, 1998). Despite the ongoing need for this service, the number of health care facilities which offer abortion care continues to decline. From 1982 to 2000, the number of abortion providers decreased by thirty-seven percent. Abortions are now available at only 1,819 clinical locations, maldistributed across and within states, resulting in extreme consolidation of abortion services. One quarter of all abortion providers are specialized abortion clinics, defined as those where at least half of patient visits are for abortion services. Eighty percent of abortions are provided by clinics which perform more than 1,000 abortions per year (Finer & Henshaw, 2003).

In 1988 a new abortion technology, known as RU486, was introduced in France. Also called the "abortion pill," RU486 is taken by a woman to induce a miscarriage. This process is generically referred to as a "medication abortion." Because performing a medication abortion does not involve the use of instruments nor does it require anything invasive on the part of the provider, RU 486 affords great potential to expand the pool of providers offering abortion care. Abortion supports predicted that a large number of new physicians would begin offering medication abortion once mifepristone, the generic name for RU486, became available in the United States. The effort to approve the drug in the United States, however, took over twelve years and since its approval in 2000 adoption by non-abortion providing clinicians has not met earlier expectations.

This dissertation explores the implications of medication abortion for abortion care provision in the United States. Section I provides an overall theoretical framework which guides the substantive work undertaken. A sociopolitical history of abortion in the United States is presented in Section II. Section III includes material specifically related to medication abortion

Overview of Section I

In Section I, Chapter 1, a theoretical framework is developed which illuminates what is unique about abortion as a social issue. Building from the Estes (2001) multi-level analytical framework to help explain contemporary social policy, this chapter proposes a refined model that can be used to better understand abortion social policy. This refined model recommends seven adaptations: 1) Expanding beyond ideology to explicitly include hegemony; 2) Adding "Biological Sex" back into the interlocking systems of oppression; 3) Broadening from the sex/gender systems to a larger set of cultural system(s); 4) Adding feminist critiques of the state as the protector and grantor of rights; 5) Recognizing the absence of rather than control by post-industrial capital; 6) Moving from citizen/public to inclusion of collective social movements; and 7) Disaggregating the Medical Industrial Complex/Aging Enterprise to the components of health care system(s).

Chapter 2 takes up the theories of social movements, briefly reviewing the four major theoretical strands in social movement research. The strands: resource mobilization, political process, New Social Movements, and framing, are not positioned against one another but rather this chapter seeks to cull contributions from each perspective to help understand the social movements that surround the abortion debate in

the United States. Key concepts taken from these approaches that inform discussions in the substantive portion of this dissertation include social movement organizations, countermovements, ideology, tactics and outcomes, gender, and health social movements.

Overview of Section II

Section II of this dissertation (chapters three through nine) provides a socio-political history of abortion in the United States. Contemporary analyses of abortion in the United States often locates the site of contestation about abortion within its religious or moral implications. This understanding of abortion, however, is void of a historical understanding of how abortion was first problematicized as a concern of physicians. Abortion opposition served initially as a means by which to consolidate the growing power of profession of medicine. In this way, abortion was "medicalized before it was moralized." The sociolpolitical history of abortion presented in this section of the dissertation traces the trajectory of abortion from common and accepted to its' current location at the heart of a polemic social movement debate.

Chapter 3 explores the history of abortion in the United States as a component of the professionalizing project of medicine from the mid 19800s to the mid 1900s. Revealed are the ideologies of medical practices/knowledges that produce the meaning and the availability of abortion in the modern era. Informing this discussion are theories of professionalization. This chapter argues that the professionalizing project of medicine occurred within the larger context of a gender/race/ethnic hegemonic social structure of elite power which opposition to abortion helped to maintain. Central to this hegemony is the naturalness of women's reproduction and the idea that abortion is a disruption of a "natural process." Produced from this is a particular meaning of "life" that is both

created and recreated by the disciplining power of medicine. Theories of biopower contribute to this argument and thus are briefly reviewed. This way of understanding abortion can be understood as gendered ideology.

Through the production of a medical meaning of reproduction, control over abortion became the domain of medicine. In this, abortion was separated into two types, criminal and therapeutic; the latter was abortion as deemed necessary by medicine. Enforcement of criminal abortion laws further perpetuated the hegemonic power elite structure and continued to discipline women's behavior that challenged accepted ideologies of sex and gender. Unfortunately criminal abortion did not make abortion disappear and medicine was forced to deal with the consequences of both illegally performed and self-induced abortion. The availability of therapeutic abortions further complicated society's treatment of abortion. Advances in maternal health made justifications for abortion to "save a woman's life" increasingly ambiguous. Efforts to establish standards for abortions through the therapeutic abortion committees did not resolve the situation.

Both as a result of needing to bring abortion regulation into alignment with medical practice and out of concern for the women suffering from criminal abortion statutes, medicine began to push for abortion law reform in the early 1960s. Physician engagement in abortion law reform and repeal is the subject of Chapter 4 of this dissertation. Public attention was brought to the issue of reform as a result of several high profile cases that demonstrated the need for abortion for women whose fetuses were at risk for genetic abnormalities. Also critical to garnering public support for abortion reform was the recapitulation of the "tale of the illegal abortion."

The first reform efforts sought to allow abortion for a limited number of circumstances and still within control of the domain of medicine. As such physicians were actively involved in efforts to secure abortion reform. However, legal reform failed to address the actual "abortion problem" because so few women needed abortions for the reasons allowed under reform. The ongoing limitations of reform laws for the practicing physician converge with a growing women's movement that began to articulate abortion as a women's right. Collectively these groups would push for abortion law repeal, initially through the legislative process and subsequently through the courts. These efforts would be rewarded with the 1973 *Roe v Wade* decision that legalized abortion. Theories of policy diffusion help to explain the trajectory of abortion legislation and the need for judicial intervention.

Chapter 5 examines two socially constructed understandings of abortion that would have enormous implications for the trajectory of abortion after *Roe*. The first of these, the "Abortion Clinic," is produced from an interaction between the freestanding clinics that emerged to deal with large volume abortion demand in New York prior to *Roe*, and the failure of hospitals to begin offering abortion care after *Roe*. Theories of medical geography help explain how the place where abortions occur became a "space" imbued with social meaning. The specialization of abortion care into these abortion clinics further separated abortion from the rest of the health care delivery system. The physical separation made these clinics identifiable and easy targets for the direct action wing of the pro-life movement. The meaning of abortion as constructed as space was inseparable from an understanding of abortion as contentious politics.

The failure of mainstream medicine to embrace abortion providers resulted in the specialization of abortion care where most abortions are done by a small number of physicians. The second social transformation occurred through the stigmatization of these physicians through the label "abortionist" that linked the physicians with the legacy of corruption and incompetence of the back-alley abortion provider prior to *Roe*. These physicians are further demonized through calls of "murder" and "baby-killer." New physicians do not take up abortion care both because they are not trained in such care and also because of the social and professional costs of providing such care.

Two umbrella social movements developed in response to the *Roe* decision and subsequent challenges to it. Chapter 6 examines the pro-life movement using the key concepts of social movement theory laid out in Chapter 2. The discussion is divided into a review of social movement activity geared at mainstream political engagement followed by an analysis of the direct action efforts. The social movement organizations as well as the tactics employed are discussed. Where they have been studied I review the meaning of social movement engagement for pro-life activists. Finally the outcomes of social movement efforts are assessed. Recognizing the importance of framing in discussions of abortion, I also review the three major frames used by the pro-life movement: "life" and the fetus, the culture war, and women's health.

Chapter 7 addresses the pro-choice movement and its' efforts to respond to the pro-life movement's successes and frames. Unfortunately less scholarly attention has been paid to this movement and thus the review is less substantive that that of the previous chapter. Three major social movement concepts focus the review: social movement organizations, tactics, and framing. The lack of a pro-abortion wing of the

pro-choice movement is taken up analytically to reconnect the discussion to the notions of ideology and hegemony posited highlighted in the theoretical model proposed in Chapter 1.

Chapter 8 is the reproduction of a synopsis of the material presented in Chapters 3 through 7. This material has been accepted for publication in Ritzer, G (ed), *Encyclopedia of Sociology*, Blackwell Publishing, forthcoming 2006. Guidelines for preparation of this manuscript limited the number of cited references to 20. As such, sentinel text were selected from the material included in Chapters 4-8. At the direction of the editor a small section on the international implications of the abortion social movements is included.

Overview of Section III

In Section III, the specific issue of medication abortion is addressed. The work presented reflects both theorizing about what might advance the use and availability of mifespristone in the United States as well as empirical work to this end. Before discussing the chapters of the section, a brief description of medication abortion is provided.

To induce a medication abortion a pregnant women initially takes the drug mifepristone and subsequently follows it with use of a second drug, misoprostol, a generic prostaglandin. The FDA labeling for Mifeprex®, the registered mifepristone product in the US, recommends use in women who are less than 49 days from their last menstrual period (LMP), aka seven weeks pregnant, and involves 600mg of mifepristone followed 48 hours later by 400mcg misoprostol taken orally. Care includes three clinical visits with in-office administration of the misoprostol and observation while passing the

pregnancy. Ongoing medical research has refined the clinical regimen used to perform a medication abortion allowing for more flexibility in how the abortion is performed and in extending the gestational limits to 63 days LMP (aka nine weeks). In the widely used evidence-based regime 200mg mifepristone is followed by 800mcg misoprostol inserted vaginally 24-72 hours later. Instead of three visits the evidence-based regimen recommends two clinical visits with the patient using the misoprostol at home rather than in the healthcare facility. There is wide-spread agreement among clinicians and researchers of the preference and scientific strength of the evidence-based regimen (American College of Obstetricians and Gynecologists, 2005; Stewart, Wells, Flinn, & Weitz, 2001)

Chapter 9 begins by explaining the rational for the selection of the terminology used to describe an abortion using a pharmacologic product, i.e. "medication abortion." Initially this type of abortion was referred to as "medical abortion." This phrase, however, can be confusion since, for women, all abortions are "medical." To try to create greater clarity about what is involved in the use of mifepristone, a more precise description "medication abortion" was forwarded. An editorial advocating for this terminology published by Weitz and colleagues in *Contraception*, 69(1), 77-78 and is reproduced with permission here. The phrase "medical abortion" is still used in the literature and thus the phrases are often interchangeable through Section III.

Chapter 10 addresses how the drug used in medication abortion, mifepristone, is treated differently than other similar types of health care. An article, "Normalizing the exceptional: incorporating the 'abortion pill' into mainstream medicine," published in *Social Science and Medicine* 2003(56):2353-2366 by Joffe and Weitz is reproduced with

permission here. After offering a brief historical overview of the protracted struggle for FDA approval of mifepristone in the US, this paper discusses the typical processes for integration of a newly approved medication into mainstream medicine and contrasts this process with the special challenges posed by a drug that is associated with abortion. The article outlines the challenges to implementation, including both external and internal obstacles. It discusses such external obstacles as the conflict between the FDA-approved regime and an evidence-based alternative; the necessity for physicians to order and dispense this drug; the ambiguity over the need for ultrasonography; and insurance reimbursement, malpractice, and other legal issues. Internal issues addressed include "turf issues" between medical specialties and between physicians and advanced practice clinicians as well as concerns over "cowboy medicine", and patient compliance. This paper concludes with an exploration of the sociological implications of this effort to "normalize the exceptional."

Chapter 11 further examines one of the external barriers identified in the previous chapter, namely that of malpractice coverage. The effect on the provision of medication abortion which results when medication abortion is treated differently by malpractice/liability carriers is explored. This article, written in collaboration with two attorneys from the Center for Reproductive Rights is the summary of a much larger legal analysis of the potential for legal remedies to malpractice practices surrounding coverage for medication abortion. Unfortunately, avenues for challenge restrictions on the "business" side of abortion are very limited. Private liability carriers have the right to treat abortion differently as abortion providers are not a protected class. This article presents options for primary care providers who do not have liability coverage for

aspiration (aka surgical) abortion but want to offer medication abortion services. This article is under review at a women's health journal with the goal of making the information available to primary care providers who do not currently offer abortion services.

Chapter 12 takes up the issue of how medication abortion has been integrated into the social constructions of the abortion clinic and the abortionist which was illuminated in Chapter 5. A paper ""Six Feet Under Brings Abortion To The Surface," by Weitz and Hunter, published as part of a special issue on medication abortion in *American Sexuality*(1): http://nsrc.sfsu.edu/HTMLArticle.cfm?Article=201& PageID=60&SID= 2B9A6BF3307A77DA1465574290FD14ED is reproduced with permission here. This article addresses the discourse used to describe abortion and the lack of inclusion of medication abortion in bulletin board postings by fans of the television program *Six Feet Under.*

Chapter 13 presents the formative work conducted to try to understand how physicians learn about advances in women's health. The goal of this work was to compare how non-abortion providing physicians routinely learn about new women's health advances with how similarly situated physicians are learning about and implementing medication abortion. The results of this project were to be used to help guide the development of an intervention to expand the availability of medication abortion services in underserved areas. The paper reproduced as this chapter was submitted for review to *Health* and reports on a small qualitative study to gather information from community-based physicians practicing in Arkansas in a country without an abortion provider. Data from qualitative interviews with primary care

physicians in Arkansas presents a preliminary picture of how "women's health" providers learn about new advances and what role the pharmaceutical companies are playing in that process. Supporting literature is reviewed to locate these results within larger explorations of the pharmaceutical industries efforts to influence physician prescribing behavior. Two case examples, depression and anxiety treatment in women and patient preference for a brand of oral contraceptives illuminate the successes obtained by the pharmaceutical companies in expanding use of their products. Based on these results, recommendations are made that medication abortion be "sold" like other women's health technologies using the techniques of pharmaceutical detailing.

Chapter 14 takes up this recommendation and describes a project undertaken to conduct "academic detailing" of medication abortion to primary care physicians in rural California. "Academic detailing" is the process of using one-on-one interactions with physicians to alter physician behavior. This technique dates to the early 1980s when it was first used to address high rates of inappropriate use of antibiotics. Chapter 14 is the reproduction of an article summarizing the results of the academic detailing study undertaken. The article has been submitted to the *Journal of Health and Social Behavior* for review.

For the project described in this paper, physicians practicing in eight rural California counties (n=1428) were asked to complete baseline and follow-up surveys. Between the two surveys, clinician educators visited a random sample of physicians (n=218) to conduct a six-month academic detailing intervention disseminating standardized tiered messages and materials related to medication abortion. This paper reports the findings from the baseline survey related to opinions about abortion in general

and medication abortion specifically as well as the results of the academic detailing intervention. Statistically significant changes in physicians' willingness to provide medication abortion were found for physicians who received academic detailing. However, the process was labor intensive with large numbers of practice visits and very short face-to-face interaction periods. Recommendations for future replication efforts are provided.

The results of this study suggest that academic detailing may be one means by to reach physicians without prior knowledge of or interest in providing medication abortion. The almost universal support for legal abortion among physicians in the study and the low levels of moral opposition to abortion provision suggest that values barriers are not the major obstacle to overcome. Additional encouragement for abortion diffusion is found in opinions of physicians that women in their communities would benefit if abortion services were more widely available and the belief that mifepristone can be offered safely in a primary care setting. Questions about these attitudes may serve as appropriate screening tools for future identification of physicians with a greater likelihood of adopting medication abortion.

Several lessons from this project have implications for other academic detailing efforts generally and in regards to medication abortion specifically. Better identification of targeted health care providers should be complemented with interventions at the practice rather than the individual level. In addition, attention to the specific needs of the so-called "gatekeepers" is important to the success of any academic detailing undertaking. While the number of products being detailed should be limited, the content of what is being detailed should be more comprehensive than simple introduction of the

technology. In the case of medication abortion, the information detailed should address how to make abortion referrals, the need for expanded access to abortion, as well as how to incorporate abortion services into clinical practice.

The work to expand access to abortion care and to understand the implications of medication abortion on abortion care provision in the United States is ongoing. As such, the conclusion, Chapter 15, explores potential next steps in integrating medication abortion and in understanding abortion as a health care service. Future work in this area affords the potential to rupture the "abortion is problematic" hegemony that is now a taken for granted in contemporary America.

Author Standpoint

Because abortion is so highly contentious much of what we know has been developed within the context of a highly charged debate. My own active involvement in efforts to expand access to abortion care no doubt creates dilemmas for me as an abortion researcher. However, I believe, like many feminist scholars, that the personal and the professional should not be separated and that my location as an activist enhances rather than inhibits my capacity to conduct quality research. In this way I respond to Smith (1990:12) who asks, "how a sociology might look if it began from women's standpoint and what might happen to a sociology that attempts to deal seriously with that standpoint."

Rather than striving to detach my research from my work, I seek to meet the challenge of praxis set out by Marxist and neo-Marxist scholars. This notion is illuminated in more detail by Gouldner (1970) who challenges the assumptions of what generated social theory. He contends that "Reflexive Sociology" is concerned with what

sociologists want to do and with what they actually do in the world. Gramsci (1957) called these scholars "organic intellectuals." He advocates for the development of these as revolutionary intellectuals who can disrupt the existing hegemony. These concepts of sociologist as having effect in the world are now forwarded in calls for conducting "public sociology" (Burawoy, 2005). This dissertation reflects my attempt to meet this challenge.

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Section I: Theoretical Framework

CHAPTER 1: A FRAMEWORK FOR STUDYING ABORTION

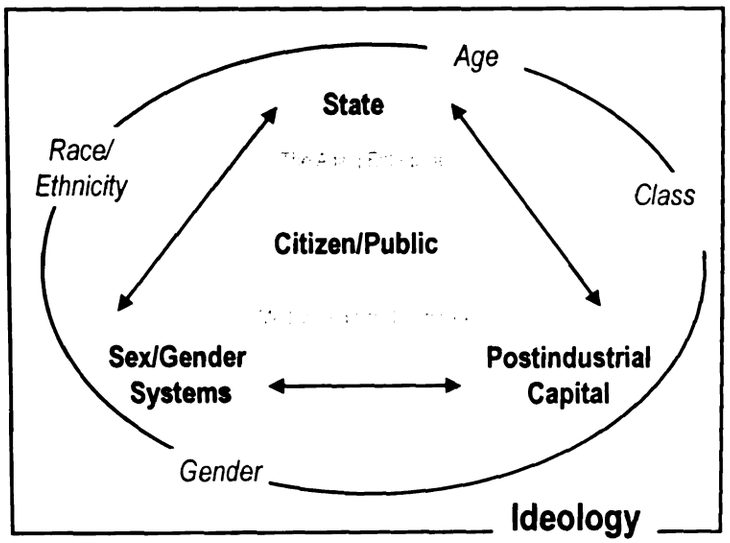
After almost three decades of work, Estes (2001) has developed a multi-level analytical framework to explain contemporary social policy. This model provides an important starting place to understand how abortion is simultaneously similar to and different from other social issues in the US. This chapter reviews the Estes model and proposes a refined model that can be used to help understand abortion social policy.

The Estes Model

Estes (2001) multi-level framework is developed within the conflict theoretical tradition in sociology and helps to elucidate the socially and structurally produced nature of social policy. Unlike the functionalist perspective that stresses the way the various parts of society work together to maintain social order, the conflict perspective views struggles as the central force in shaping arrangements in society (Kardaras, 1995).

The Estes model for understanding social policy in aging is reproduced in Figure 1 and includes five levels of analysis: 1) financial and post-industrial capital and its globalization, 2) the state, 3) the sex gender system, 4) the public and citizen, and 5) the "medical industrial complex" and the "aging enterprise." Overlaying these relations are the "interlocking systems of oppression" (P. H. Collins, 1990) of gender, class, age, and race/ethnicity. Infused in these arrangements is ideology. Policies result from the outcomes of struggle among actors in the model. Actors here are understood to human beings as well as structures, discourses, actions, and technologies. The model is sensitive to the connections of societal (macro-level), organization and institutional (meso-level), and individual (micro-level) dimensions.

Figure 1: Estes (2001) Model



Each of the components of the Estes (2001) model is taken up in the discussion below, moving from the outside of the model inward. Based on this discussion the model is adapted to be more appropriate for understanding socially contested issues such as abortion. The following adaptations are proposed:

Expanding beyond ideology to explicitly include hegemony

Adding "Biological Sex" back into the interlocking systems of oppression

Broadening from the sex/gender systems to a larger set of cultural system(s)

Adding feminist critiques of the state as the protector and grantor of rights

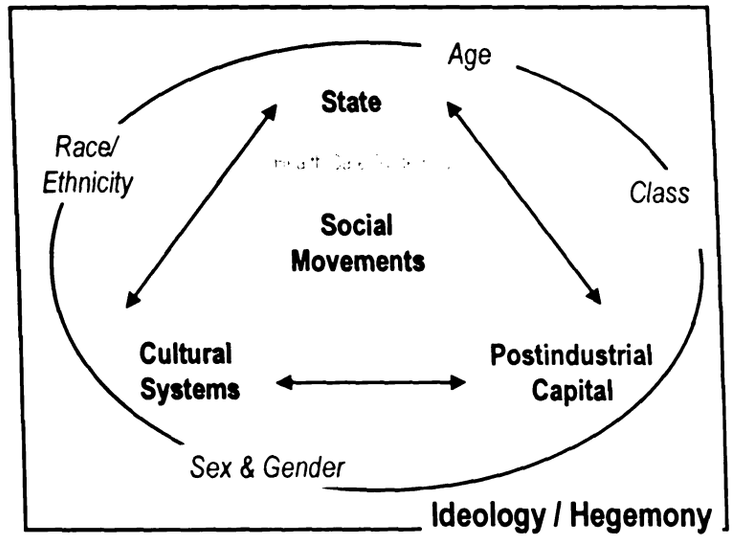
Recognizing the absence of rather than control by post-industrial capital

Moving from citizen/public to inclusion of collective social movements

Disaggregating the Medical Industrial Complex to the components of the health care system(s)

A refined model is in Figure 2 and guides the work undertaken for this dissertation.

Figure 2: Weitz Adaptation of Estes (2001) Model



Adapting the Estes Model to the Study of Abortion

Expanding beyond ideology to explicitly include hegemony

Ideology reflects the interests of dominant groups as a way to perpetuate their privilege (Johnson, 2000). Ideologies themselves serve as legitimating myths by providing moral and intellectual justification for the differential distribution of power, privilege and status among social groups (Sidanius, Pratto, & Bobo, 1994). Ideologies are not false beliefs that may be contrasted with scientific truths (Therborn, 1980). Rather, ideologies are competing world views that reflect the social position and structural advantages of their adherents (Estes, 2001). These concepts of ideology are derived principally from the writings of Karl Marx [1818-1895] (see the German Ideology 1978 [1932]; Society and Economy in History, 1978 [1946]; the Manifesto of the Communist Party 1978 [1888]). In his work Marx outlined the science of ideology that bound together his philosophy of consciousness and his philosophy of history, to

create a tight, linear logic (Brown, 2001) linking class, structure and ideology (Giddens, 1971).

Often confused with theories of ideology, the notion of hegemony is closely related but theoretically distinct from ideology (Eagleton, 1991; Hamilton, 1986). As the Estes model is embedded in conflict theory it assumes notions of hegemony. However, hegemony is not called out separately from ideology. As such the adaptation of the Estes model explicitly includes the distinct concepts of hegemony.

The original contribution of hegemony as a idea is often associated with the social theorist Antonio Gramsci [1891-1937] who built from Marx's earlier work on ideology. Modern scholars from both Europe and the United States have further refined the understanding and uses of notions of hegemony. For Gramsci (1971 [1929-1935]), maintenance of power requires that the institutions, hierarchies, ideas, and social practices be accepted as the natural order of things. Hegemony is thus the process whereby the ruling group comes to dominate by establishing those values and beliefs that go without saying (Hennessy, 1993), articulating and renewing a prevailing "'common sense' mentality in society as a whole" (Brooker, 1999:99). Hegemony is "the taken for granted practices and assumptions that make domination seem natural and inevitable to both the dominant and the subordinate" (Glenn, 1999:13). Mouffe (1979:184) calls this process a "higher synthesis" of elements fused to produce a "collective will." Gramsci's concept of hegemony enables scholars to see how common sense values are actually the product of an enforced consent, conveyed through the institutions of civil society and through culture (Dietzel & Pagenhart, 1995). Sassoon (1987a:xi) further explains this argument "[Gramsci's] writings make clear that the political basis of hegemony and the

material foundations for the influence of dominant ideas are firmly rooted in the kinds of compromises which must be struck."

In contemporary American society there is a shared understanding, or hegemony, that abortion is problematic. Even among those that support the right to legal abortion, abortion is often called "a necessary evil" or an "understandable sin." Abortion is distinguished from other forms of birth control in both law and public discourse. While an acceptable back up option, public opinion polls show that most Americans do not believe abortion should be used as primary method of contraception (see www.gallup.com). Likewise there is a general belief that a woman should not have multiple abortions. Advocates for abortion rights are quick to retort that although they are "pro-choice" they are not "pro-abortion" (see www.naral.org). In this way, pro-choice and pro-life can be understood as ideologies within a larger hegemonic idea that "abortion is problematic."

This idea that abortion is problematic is situated in a particularilized meaning of fetal life which developed from the process by which medicine gained control over the meaning and provision of abortion. As will be discussed in greater detail later in this dissertation, the industrialization of the mid eighteen century fundamentally changed ideas of society, production, and value. At the same time the rise of the modern science of medicine created new understandings of the relationship between women's bodies and the developing fetus. Through the practices of medicine this view of the fetus as life became enshrined in science. Domination of female reproduction was thus justified not only for historically accepted cultural and religious reasons but also for scientific ones.

As Gramsci has posited, the linkage of the taken-for-granted with the intellectuals that produce knowledges to sustain that understanding is a critical component of hegemony.

There currently exists no counter discourse to the idea that the fetus is life and that abortion is thus inherently problematic. Even when abortion is accepted it is done within the context of recognizing a woman's right in balance with the rights of the developing fetus. This fetus is seen and discussed as separate from that body, although housed within. Such a meaning had been reaffirmed and reified though three decades of Supreme Court decisions regarding abortion that articulate a compelling state interest in the developing fetus and potential life. "Viability" is now a medical definition that confirms a time when life, within the female body, is distinct from it.

Discussions of the taken for granted are difficult since they seem to question a "given." However, as Garner (2000:270) notes: "The best kind of hegemony is the most effortless kind... at its most effective [it] keeps us from thinking subversive thoughts or dreaming of rebellion." As will be discussed later in this dissertation, there is no "pro-abortion movement" that argues that abortion is good for women, or the better alternative to childbirth. Rather abortion even when understood as necessary is not "good."

Adding "Biological Sex" back into the interlocking systems of oppression

In her updated work on interlocking systems of oppression, Collins (2000) argues that there are multiplier and layering effects of race, class, gender, ethnicity, sexuality, nation, and age. For Collins, there is a conceptual distinction between interlocking oppression and intersectionality as race, class, gender, ethnicity, sexuality, nation, and age are interrelated axes of social structure not simply features of experience. The Estes (2001) model highlights the unique contribution that each of these systems of oppression

makes to social policy of aging. She argues that attention to gender helps explain how the status of women is created and reinforced by the political and economic structures and how the disadvantages of social class and race/ethnicity are cumulated for women across the life span.

Within feminist scholarship there exists substantial debate as to definitions of the concepts of sex and gender, which can be seen as separate, integrated or mutually constitutive. When viewed as distinct concepts sex is seen as the binarised physical anatomy (female and male) and gender the cultural interpretation and expression of the sexed body (Owen, 2000). De Beauvoir (1953), who wrote that "one is not born, but rather becomes a woman," is most frequently credited with the modern feminist usage of gender, as distinct from sex. The distinction of male from female is seen as a patriarchal invention designed to promote male authority (de Beauvoir, 1953). By comparison maternal and radical feminists (see Chodorow, 1978; Ruddick, 1989) prefer to retain a close connection between biological sex and social roles maintaining that women's unique physiology affords them privilege in action, emotion, and knowing (see Gilligan, 1982) despite its' social disadvantage.

Scott (1999) argues that the distinction between sex and gender obscures that both are forms of knowledge. That is "if a study of women automatically leads to a 'gender analysis,' then a form of essentialism is driving the investigation...When 'gender' assumes the prior existence of sexual difference...then the sharp conceptual distinctions between sex and gender are impossible to maintain" (Scott, 1999:72). Instead, she argues for blurring the boundaries between the two concepts. Other post-modern scholars argue against the tight binding of sex and gender. The rupture between the concepts allows for

the notion of gender as performance (Butler, 1990) rather given and static. Human agency is given more room and the potential for social disruption of normative understandings of gender is generated.

This debate over sex/gender separation, however, often obscures the biological reality that only a "female" body can become pregnant. While there are "biological" females who are unable to reproduce, the capacity to create and carry a child to term still rests only within the female physiology. Pregnancy is more than simply a social construction; it has a corporal reality. The meaning and control over this capacity, no doubt, is gendered. However, to not address the biology of reproduction of the human species does a disservice to the issue of both sex and gender.

In abortion, in addition to the notions of gender that are being contested there is a fight over control of the biological process. What is at stake in abortion is the ability to blur the dichotomy between male and female at its most fundamental biological level, by disrupting the one last difference that blurring the boundaries of gender does not allow. For example, the transgender movement may be successful in moving the human body across the continuum of gender recreating male and female, but without the capacity to relocate pregnancy outside the biologic female. Thus while it is difficult to disentangle the biology of reproduction from other issues of sex and gender, it is important to keep both in any analysis of abortion and to address them as separate and mutually constitutive concepts. As such, for the purposes of this adapted model by which to study abortion, biological "sex" is put into the model with "gender."

Race/ethnicity and class continue to play critical roles in the power arrangements surrounding abortion policy. No adaptation of the model is made at this level. The role

that these factors play in abortion policy and provision is taken up in later chapters. Likewise age is seen as critical to an analysis of abortion in contemporary society and is thus left in the model without adaptation.

Broadening from the sex/gender systems to a larger set of cultural system(s)

Many contemporary feminist scholars have explored the unique contribution of the sex/gender systems to the perpetuation of social structures and arrangements that privilege men over women and notions of masculinity over femininity. Estes (2001) model accords the sex/gender system a similar magnitude of importance at the institutional level as post-industrial capital and the state. However, such an approach does not explicitly incorporate other relevant cultural systems, which while contributing to the sex/gender system(s) are not one in the same. According to Swidler (1986), culture is more than a single value system, rather it is a "tool kit." Polletta (2004) offers an alternative conceptualization of culture as the symbolic definition of all structures, institutions and practices where symbols are understood as signs that have meaning and significance through their interactions. In this way culture is both patterned and patterning, both enabling as well as constraining. In addition to studying culture outside of political structures, Poletta argues for studying the cultural dimensions of political structures.

The issue of abortion is infused with both the structures and meanings produced by the sex/gender systems as well as other cultural systems including religion and science. As such, the revised model subsumes the sex/gender systems within a larger label of "cultural systems." The proposed refinement of the Estes model should not be seen as diminishing the priority of the sex/gender systems in understanding current social

arrangements surrounding abortion. Rather the opposite. The sex/gender systems are critical pieces of any analysis. A discussion of abortion, however, would be incomplete without a more explicit discussion of other important cultural systems including religion and science and as such they are added to the revised model.

Religion as a Cultural System

Religion is defined as a social arrangement designed to provide a shared, collective way of dealing with the unknown and the un-knowable, primarily organized around the sacred elements of human life (Johnson, 2000). Central to any discussion of religion is the work of Durkheim (1965 [1912]) who distinguishes between the sacred and the profane. The profane world is all we know through our senses and the sacred is all that exists beyond the everyday (Johnson, 2000). For Durkheim religious beliefs are symbolic means of understanding the power of society to fashion the individual (Seidman, 1998) Central to his work on religion is the idea that this unified system of beliefs and practices relative to sacred things facilitates social cohesion (Durkheim, 1965 [1912]).

In his classic 1966 article, "religion as a cultural system," Geertz argues that religion can be understood as a system of symbols that establish order by affirming that life is comprehensible. Religion, for Geertz, is thus about the meaning of the world as opposed to beliefs about it (Williams, 1996). In this understanding religion is seen as providing a clear sense of what is as well as what ought to be. For Geertz, religion is understood as a social not an individual product, and is a means for ordering relations among societal members. It is an interpretive approach in which religion simultaneously expresses images of reality and shapes that reality.

Hart (1996) argues that social movements scholarship often ignores the role of religion. To redress this omission, Williams (1996) argues that religion can also be understood as a political resource. Such an approach allows for examining the way in which the moral authority of religion is used to connect political action to "God's will" (Williams & Alexander, 1994). In this way religion is important to any analysis of hegemony (Fulton, 1987) as well as of politics and collective action (Williams, 1996).

Religion as cultural systems play extensively in understanding of abortion in contemporary United States. As is discussed later in this dissertation the initial opposition to the *Roe v. Wade* decision was led by the Catholic Church through its subordinate National Conference of Catholic Bishops (NCCB). This latter group would provide the foundation for the formation of a large "Pro-life" social movement and the social movement organizations that now sustain the movement. Opposition to abortion would become a central feature in the political agenda of the Religious Right. Today religiosity is the largest predictor of one's position on abortion. The meaning of anti-abortion activity is often articulated in the language of religion (see Mason, 2002; Maxwell, 2002). Recent work by Munson (2004) on the relationship between religion and anti-abortion activity explores how abortion opposition is more than just a religious position but can be understood as religious practice. The relationship between abortion and religion is taken up in greater detail later in this dissertation.

Science as a Cultural System

Weber's work on the history of religion traces the origins of rational action in contrast to magical thought thus setting up a distinction between religion and science (Garner, 2000) In explaining the history of religion Weber uses the terms "asceticism"

and "mysticism" as polar concepts (Gerth & Mills, 1946) In contrast to religion, science is thought to reflect the objective truth, that is, knowledge about the way things are, not just how they are imagined (R. Collins, 1994). Often used synonymously with empirical, science is both the process and the outcome, the methods and the results. It is a way to organize the world so that is can be understood, and proven true.

The existence of objectivity, the core of science, is a monolithic and immutable concept dating to the seventeenth century (Daston, 1999). Early scholars of science, however, argue that science is a product of certain historical and economic conditions. Science is also seen as a series of nested layers of institutions (R. Collins, 1994). For Haraway (1997) science can be understood as cultural practice and practical culture. By understanding science in this way, the ongoing debate in sociology between realism and constructionism need not be resolved (Biagioli, 1999). Rather it becomes possible to follow how science transforms society and redefine both what is made of as well as what are its aims (Latour, 1999). Thus science is understood as "politics by other means" (Latour, 1999:273).

Science's existence is a taken for granted and thus is studied not with questions that ask what science is, but rather how science works (Biagioli, 1999). Of particular interest are the laboratories (Latour, 1999). Latour describes the practices in which scientists and technologies are engage reconfigure the social world as they create natural knowledges (Golinski, 1998). In this way science studies is also interested in the practices of science.

Science is an important cultural system for understanding abortion in contemporary America. Central is the very definition of pregnancy and abortion. As will

be discussed later in this dissertation, pregnancy was initially a condition that only a woman could diagnose, done so when she felt fetal movement, or "quickening" as it was called. The formation of the medical specialty of obstetrics and gynecology transitioned the diagnosis of pregnancy from the woman to the field of medicine. As technology was developed to provide the tools to diagnose pregnancy hormones in the blood the woman's participation in pregnancy diagnosis was eliminated. Today, pregnancy is defined in medical terms as the point at which the fertilized egg implants in the uterine wall. This "scientific" definition of pregnancy is often juxtaposed with the Catholic interpretation that "life begins at conception." Thus the systems of religion and science are posed in opposition to one another.

The medical understanding of pregnancy and abortion was written into law in *Roe v. Wade* and reaffirmed with three decades of Supreme Court decisions. The implications of this reification are explored in detail in the social political history section of this dissertation.

Adding feminist critiques of the state as the protector and grantor of rights

The role of the state as a site of analysis has had theoretical development in the work of numerous scholars including Alvin Gouldner (1970), James O'Connor (1973; 1998), Clause Offe (1984), Jeurgen Habermas (1975), and Estes and Associates (2001). Feminist theorists of the state including Gayle Rubin (1975), Catharine MacKinnon (MacKinnon, 1987, 1989) Anne Showstack Sasson (1987b), Joan Acker (1988) and Wendy Brown (1995; 2001) build from these ideas, however positing that the contradictions that result from the gendered nature of the state cannot be ignored. Theorists concerned with issues of race/ethnicity have further taken up the state

examining how racism has been institutionalized through political apparatus (Blauner, 1972; Conley, 1999; Massey & Denton, 1993; Omi & Winant, 1986; Wilson, 1996).

In discussing the role of the state in her model, Estes focuses on the control and use of financial resources. She argues that the state actively participates in power struggles over political, material and symbolic resources, while reflecting various forms of the interests of the most powerful. Her model however, does not examine the problematic nature of claims for protection from the state which are central to the abortion discussion. As such this adaptation of the model incorporates this level of critique which is given sophisticated analysis in the work of Brown (1995; 2001).

Brown (1995) contends that liberals and theorists from the left have derailed two decades of Marxist critique of the instrumental use of the state in the interest of post-industrial capital for a defense of the state as affording individual protection for the abuses of the market. Brown argues that the focus of much of the recent progressive political agenda has not been concerned with the democratizing power of the state but rather with the distribution of goods, and with the pressuring of the state to buttress the rights and increase the entitlements of the socially vulnerable or disadvantaged. She contends that many Western leftists have forsaken analyses of the liberal state and capitalism as sites of domination, choosing instead to focus on their implications in political and economic inequalities. Simultaneously, progressives have implicitly assumed the relatively unproblematic instrumental value of the state and capitalism in redressing these inequalities. Of concern for Brown is that while the left was failing to be critical of the state, assault on the state from the Right allowed for the consolidation of power, not through the process of expansion but rather though deregulation and

privatization, what she terms postmodern techniques of power (Brown, 1995). In addition, the anti-state Right has claimed for itself the freedom-as-rights discourse, reacting against what they claim to be special rights (Brown, 2001) such as abortion.

For Brown (1995) the state is still an important site of critique. She clarifies that although we speak about the state as an "it," it is really a unbounded terrain of powers and techniques, an ensemble of discourse, rules and practices, (co)existing in limited and contradictory relations with one another. She posits two reasons for a need for a full and complex reading of state powers. First, the state figures prominently in many of the issues that divide modern North American feminisms, i.e. pornography, reproductive technology, parental leave, etc. Second, an unprecedented and growing number of women in the U.S. are today directly dependent on the state for survival. She explains that her interest in developing a feminist critique of the state was prompted "by concern over the potential dilution of emancipatory political aims entailed in feminism's turn to the state to adjudicate or redress practices of male domination" (:ix).

Although her work theorizes about the state as a largely negative domain for democratic political transformation it is not grounded in the traditional feminist critique that the history and genealogy of the state are as a mirror and accomplish of male domination. Rather her effort to deconstruct the state traces its "gender" in the mediations of capitalism, welfarism, and militarism as well as in the liberal and bureaucratic discourses through which legislation, adjudication, and policy execution transpire. Brown argues for developing a feminist critical theory of the contemporary liberal, capitalist, bureaucratic state through the identification of the elements of the state that are conventions of power and privilege constitutive of gender within an order of male

dominance. "Put another way, the masculinism of the state refers to those features of the state that signify, enact, sustain, and represent masculine power as a form of dominance" (:167). For Brown is it important to talk about masculinist power rather than the power of men. While the state power is marked with gender, the same aspects of masculinism do not appear in each modality of state power. "Thus, a feminist theory of the state requires simultaneously articulating, deconstructing, and relating the multiple strands of power composing both masculinity and the state" (:177). It is important to recognize that male dominance is not rooted in a single mechanism as domination by capital is. Thus the relationship between male dominance and the state is multiple, diverse, and unsystematically dynamic. And as such, there is no single thread that unravels the whole of the state or masculine dominance.

Brown is concerned with the ways in which appeals based on identity politics reinforces the power of the state. She explicitly questions whether the state is a specifically problematic instrument for feminist social change. She argues that efforts to outlaw hate speech and pornography powerfully legitimize the state as such apparently well-intentioned attempts harm victims further by portraying them as so helpless as to be in continuing need of governmental protection. Whether one is dealing with the state or husbands, the heavy price of institutionalized protection is always a measure of dependence and agreement to abide by the protector's rules. Thus, there is an inherent dialectic in the demand for rights. As a result of these institutions and discourses, disciplined subjects are (re)constructed for whom discipline becomes the stuff of desire and they ceases to desire freedom. This formulation of liberty replicates that of the sovereign subject of liberalism whose need for rights is born out of the subjection by the

state, out of an economy that ignores human needs, and out of stratifications within civil society. It reflects the bartering of political freedom for legal protection, unwittingly increasing the power of the state.

As will be discussed later in the dissertation, the right to abortion was granted in response to claims on the state to recognize it as a right of women. By introducing Brown's critique of such claims on the state, a more textured analysis can be done of the role of the state in the meaning and structures of abortion social policy. Simultaneous with the production of a "right to abortion" was the right of the state to regulate that right. Access to abortion care thus became the domain of the state and limitations on access were allowed. How the state now utilizes that power to control the meaning and availability of abortion care is taken up throughout this dissertation.

Recognizing the absence of rather than control by post-industrial capital

Most critiques of modern social arrangements focus on the power of post-industrial capital in the production of these arrangements. Estes work is highly critical of the role of capital in understanding and treatment of aging in social policy. Her work also explicitly addresses the role of corporate capital in globalization. While capital is, no doubt, present in discussion of any social issue in contemporary society, the study of abortion necessitates the examination of both the presence and absence of post-industrial capital as major actor in happing social policy.

Economic interests are not the driving force behind the modern situation of abortion in the United States. Rather than the overwhelming presence of corporate America in the social arrangements, it is the avoidance of involvement by corporate capital that makes studying abortion unique. As is discussed later in the history of the

abortion pill in the United States, corporate America deliberately backed away from engagement with the technology for fear of economic reprisal from those forces that oppose increased access to abortion (Joffe & Weitz, 2003).

The economics of abortion are rarely, if ever raised in seeking an understanding of abortion. Donohue and Levitt's (2001) article arguing that legalized abortion reduced the crime rate decades later was vilified by both supporters and opponents of abortion rights. While concerns about health care costs drive the discussion of aging in the United States, the health care costs associated with abortion and non-abortion, that is carrying an unintended pregnancy to term and delivering and raising that child, are not focal points in the discussion. Rather abortion is discussed in normative terms, whether it is good or bad morally rather than economically. Abortion represents one of the few aspects of society where market language is ignored when the social issue is taken up.

This lack of attention to the costs of abortion may in part reflect how abortion is delivered as a health care system. As is discussed in length later in this dissertation, the first success of the newly formed "Pro-life" movement was to pass the "Hyde Amendment" which prohibited the use of federal Medicaid money to pay for poor women's abortions. While states are free to use their own money, only 13 states still do so. As a result over three-quarters of all abortion performed in the United States are paid for by either health insurance or state dollars. Instead most abortions are paid for by women themselves (Finer & Henshaw, 2003; Henshaw & Finer, 2003). In recognition of this reality, most abortion providers have set the price for abortion at a level that women can afford, rather than one that secures them the most profit. The commitment to the women they serve, distinguishes abortion providers from other health care sectors when a

third party payer is the source of most revenue. A fuller discussion of the relationship between cost and abortion care is presented later in this dissertation.

In his work on the power of the conservative movement in this country, Medvetz (2004) argues that abortion plays a critical role in the cohesion of the movement which reflects the alignment of elite post-industrial capital and social conservatives. The movement is sustained by a willingness to require uncompromising positions on "Babies, Guns, and Taxes." The power of post-industrial capital to control the apparatus of the state to perpetuate its economic self interest relies on securing the support of the voting citizens who do not directly benefit from the economic policies promulgated. However, by embracing opposition to abortion, post-industrial capital controls the power arrangements of the state by securing the support of the social conservative electorate. The importance of "moral issues" in voting, despite an opposing economic self interest, is the subject of contemporary explanations of voting behavior (see Frank, 2004). A more detailed explanation of this fusion of economic and social interests is discussed later in this dissertation.

Given these power relationship, the absence of post-industrial capital is presented as critical point of inquiry when studying abortion. Thus the Estes model is adapted to reflect both the presence and the absence of post-industrial capital as a factor in the establishment and perpetuation of power arrangements in modern society.

Moving from citizen/public to inclusion of collective social movements

The Estes (2001) model includes a rich discussion of the role of citizen/public. Missing from this analysis is the role of collective action and the means by which the individual engages with the state beyond the granted rights of citizenship. In recognition

of the role that collective action plays in social policy, a revised model replaces the citizen/public with social movements. The theories of social movements are taken up in greater detail in Chapter 2 of this dissertation.

In brief, social movements are sustained, organized collective effort that focus on some aspect of social change (Johnson, 2000). Scholarship on social movements is vast and much of the work reflects larger debates within the broader field of sociology including the structure/agency debate and the structure/culture debate. While Whittier (2002) posits that many of the field's theoretical boundaries are breaking down, there are still distinct, recognized approaches within the social movements literature including resource mobilization (see McCarthy & Zald, 1977), political process (see McAdam, 1982), cultural framing (see Benford & Snow, 2000), and identity movements, known as New Social Movements (see Dalton, Kuechler, & Burklin, 1990; and Pichardo, 1997). Other key concepts in social movement scholarship that are important to the refinement of a model with which to explore the issue of abortion include: social movement organizations and counter movements.

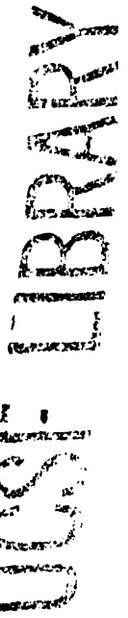
The Pro-life and the Pro-choice Movements are prototypical social movement/counter movements. These movements both produce and are constituted by the interactions between the movements' organizations, leaders, tactics, and framing. These movements are described in greater detail in Chapters 6 and 7 respectively.

Disaggregating the Medical Industrial Complex to the components of the health care system(s)

Estes (2001) argues that the social relations between the state, post-industrial capital, the sex/gender system and the public/citizen facilitated the growth of "the

medical industrial complex" (Ehrenreich & Ehrenreich, 1971; Estes, Harrington, & Pellow, 2000; Relman, 1980) and the aging enterprise in the U.S. (Estes, 1979). A central feature of both the medical industrial complex and the aging enterprise is the commodification of health (Estes, 1979) including the medicalization of old age (Estes & Binney, 1989). Within this context the incentive is to maximize profits rather than health.

As discussed earlier, the lack of apparent economic interest in abortion necessitates a revisiting of the placing of the medical industrial complex at the center of the analytic model. Instead the disaggregated components of the health care system(s) are included in the model. In this approach the actors that comprise the medical industrial complex are themselves separate sites of analysis. These actors include the profession of medicine, the mainstream health care system, abortion care facilities, health care regulations, and malpractice/liability carriers. Each of these is taken up in length within the context of this dissertation. In particular the role of the profession of medicine as both the initial leader in opposition to abortion and then as key player in advocacy for legal abortion is juxtaposed to the disengagement of the medical profession from the issue of abortion in the post-*Roe* era. The consolidation of abortion services and the lack of training in abortion care reflect the separation of abortion from the rest of the health care system. Medication abortion's unique treatment by malpractice/liability carriers is presented.



Summary

The Estes (2001) theoretical model provides a valuable tool with which to examine social issues. This chapter seeks to adapt that model by including other

components that are critical to an understanding of the social issue of abortion. Specifically the model is adapted to include the concept of hegemony as well as ideology in order to bring the "taken for granted" into the analysis. Also, the corporal reality of biological sex is resituated within attention to gender. The sex/gender systems are expanded to include other cultural systems including religion and science. The role of the state as protector and granter of rights is problematized within feminist critiques of the state. Likewise the absence as well as the presence of post-industrial capital is included in the conversation. The citizen/public is modified to address the unique contribution of social movements. Lastly, the medical industrial complex is disaggregated into the components of the health care systems. The interaction and reproduction of each of the components of the model are addressed throughout the course of this dissertation.

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CHAPTER 2: SOCIAL MOVEMENT THEORY

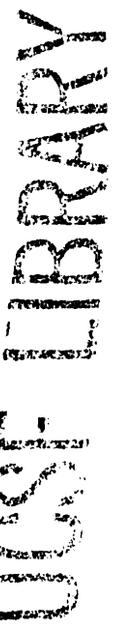
Scholarship on social movements is vast and much of the work reflects larger debates within the broader field of sociology including the structure/agency debate and the structure/culture debate. While Whittier (2002) posits that many of the field's theoretical boundaries are breaking down, there are still distinct, recognized approaches within the social movements literature including resource mobilization, political process, cultural framing, and identity movements, also known as New Social Movements. The first two theories focus on structures while the latter two stress the importance of culture. In their edited volume on current debates in social movement theory, Goodwin and Jasper (2004) articulate their belief about the state of the field:

> There is currently a good deal of theoretical turmoil among analysts of social movements. For some time the field has been roughly divided between a dominant, structural approach that emphasizes economic resources, political structures, formal organizations and social networks and a cultural or constructionist tradition, drawn partly from symbolic interactionism, which focuses on frames, identities, meanings, and emotions."
>
> (Goodwin & Jasper, 2004:vii)

Meyer (2002b) warns that scholars should avoid false dichotomies of culture and structure and instead see people who make movements as moral and instrumental actors. Likewise, Whittier (2002) argues that structure and meaning should be seen as mutually constituted, both with importance to understanding movements, rather than seeing them as alternative explanations. Social movements should also be understood as imbued with gender, race, class, and sexuality. As Whittier (2002:296) notes, "[u]nderstanding how movements are shaped by the intersections of internal and external processes, and by meaning and structure,

requires an analysis of how the racialized, gendered and classed nature of both movements and dominant institutions shape mobilization and outcomes."

The discussion below of theories of social movement does not attempt to resolve the theoretical conflicts within the larger field but rather to present a brief overview. In doing so it examines the structuralist traditions of resource mobilization and political opportunity process as well as newer cultural theories of identity and framing. It also presents other key concepts in social movement research including: social movement organizations, counter movements, ideology, tactics and outcomes, the role of gender, and health movements. Such a complex multi-layered view of social movements highlights the interplay between structure (e.g. movement organizations, communities and fields), strategies and collective action (e.g. challenges, protest events), and meanings (collective identities and discourses) (Whittier, 2002).



Structure

Resource Mobilization Theory

One established, and now highly critiqued, approach to understanding social movements is resource mobilization theory which draws on political, sociological and economic theories. First articulated by McCarthy and Zald (1977:1236), the resource mobilization model "emphasizes the interaction between resource availability, the preexisting organization of preference structures, and entrepreneurial attempts to meet preference demand." Developed to explain the protest movements of the 1960's, resource mobilization concepts provided an alternative to the collective behavior theories which focused on the irrational elements of protest (see Le Bon, 1966) and destructive large group behavior such as that of the Nazis in Germany (Meyer, 1999).

Resource mobilization stresses the ways in which movements are shaped and act within the limits of a set of political, economic, and communication resources (McCarthy & Zald, 1977). The approach emphasizes both societal support for and constraint of social movement phenomena. Central to this theory is the idea that activists do not choose goals, strategies, and tactics in a vacuum but rather are affected by the availability of resources (McCarthy & Zald, 1977). Resource aggregation requires social movement organizations (McAdam, McCarthy, & Zald, 1996). (These social movement organizations are discussed in greater detail later in this chapter.) Also required is the involvement of those outside the collectivity which the social movement represents. Because resources are necessary for engagement in social conflict, this perspective focuses on understanding how money and labor are available to those engaged in social movements (McCarthy & Zald, 1977). Collective action is thought to involve rational pursuits of interest by groups (Cohen, 1985). As a result, the approach reflects sensitivity to costs and rewards in explaining individual and organizational involvement in social movement activity. Costs and rewards are affected by the structure of society and the activities of authorities (McCarthy & Zald, 1977).

Political Process Theory

Critics of resource mobilization theory stress its highly economic perspective and adherence to rational decision making theory. The Political Process Theory developed to address the limitations of resource mobilization theory is presently considered the dominant paradigm among social movement analysts (Goodwin & Jasper, 1999). The large number of scholars in this theoretical tradition are commonly labeled "structuralists." Within this paradigm, social movements are seen as emerging from expanding political opportunities, which metaphorically represent windows that open and close (Kingdon, 1995). Most process theorists have tested their

approach on movements pursuing political participation or rights (Goodwin & Jasper, 1999). McAdam's (1982) study of black insurgency is considered the most influential example of this approach.

Central to political process theory is the role of the state, which is the critical structure in any analysis of social movements. Meyer (2002b:14) notes, "[a]s states alter the costs and benefits of collective action and develop new techniques for controlling collective action, they allow, encourage, provoke, or discourage movements' particular changing strategies of influence." The opportunities and consequences of movements with regard to the state also shape internal ideological debates and collective identity. In this way activists construct collective identities and discourses within contextual locations with regard to the state. Meyer (2002b), however, points out that recognizing the unique role of the state does not ignore that movements are also constrained by the culture and the economy in which they are embedded.

Goodwin and Jasper (2004) argue that theorists of political process tendency to see the state as a unifying structure rather than a complex web of interactions and agencies limits the usefulness of the political process theory. They go as far as to label both the political opportunity thesis and the political process model, which comprise the Political Process Theory, as "tautological, trivial, inadequate, or just plain wrong" (Goodwin & Jasper, 1999:28). This strong criticism comes from the belief that process theorists remove the meanings and fluidity out of strategy, agency, and culture. A further criticism of the political process approach is that it is unable to explain movements that do not target the state as their main opponent or that seek collective identities as a movement goal. Opponents of political process theor(ies) argue that culture, rather than politics, is the core of understanding social movements.

Goodwin and Jasper's critique of the political process model elicited response for political process theory scholars. Tarrow (1999) argues that the paradigm warfare in which Goodwin and Jasper engage is not helpful to the larger field of social movement theory and ignores much of the contribution made by decades of scholarship. Meyer (1999) finds their indictment to be a rejection of the larger social science enterprise of building theory rather than a specific critique of social movement research. While rejecting their overall criticism, Meyer (1999) acknowledges that Goodwin and Jasper raise several challenges to the political opportunity process model that should be addressed. Of particular importance is the need for more work on the connections between cultural practices, social movements, and political dissent so as to explain movements that do not make explicit political claims. Meyer rejects, however, the idea that agency can be addressed without attention to structure and agrees with Koopmans' (1999) position that cultural is inherently structural.

Tilly (1999) posits an alternative approach to the challenges raised: rather than seek to explain social movements he suggests working to explain contentious politics. In this way the scholar does not search for universal patterns at the level of whole structure or sequence but rather for analogous causal mechanisms and the conditions governing the combination and sequencing of those mechanisms. The result is reliable, transferable explanations of significant elements within complex events, processes, or structures rather than totalizing accounts of those phenomena. For Meyer (1999) the solution is in refining the political process approach by: 1) separating opportunities, mobilization and influence into more explicit categories; 2) allowing for mobilization to result from both favorable and unfavorable state policies; 3) exploring missed opportunities; 4) recognizing movement-movement influences; 5) examining political processes in non-advanced industrial country settings; 6) broadening the definition of state to a larger set of

political institutions; 7) investigating how activists choose their tactics; 8) studying public policy changes; 9) probing hard cases; and 10) clarifying the nomenclature used.

Culture

A view that resource mobilization and the political process theories' narrow focus on structures prompted increased attention to the role of culture in the study of social movements. Mueller and Morris (1992) provided one of the first efforts to explicitly return culture to social movement scholarship. This early work was followed by an edited volume by Klandermans and Johnston (1995), which although not exclusively focused on social movements, provided scholars with theories of culture that were applicable. Within this work constructionists approaches were applied to group action.

According to Poletta (2004) there are two common points of confusions regarding culture in the field of social movement research. The first is the counterposing of the structure/agency debate against the structure/culture debate thereby reducing culture to agency. The second point of confusion is that culture is often viewed solely as a sphere of activity and target of protest (as in new social movements theory—see below). A discussion of the competing definitions of culture are provided earlier in Chapter 2. Using Swidler (1986)'s notion of culture as a "tool kit," culture is understood as both patterned and patterning, both enabling as well as constraining. Two social movement theories have sought to address the prioritization of culture in the field of social movement scholarship: New Social Movements and Framing.

New Social Movements

A criticism of resource mobilization and political process theories is that they are not applicable to contemporary social movements that challenge cultural codes and promote new

lifestyles and collective identities as opposed to promoting interest politics (Koopmans, 1999). Often termed, "New Social Movements," this theoretical approach emphasizes the cultural nature of movements and views them as struggles for the production of meaning of collective identities. On a macro level the role of culture is central to New Social Movements, while on the microlevel the paradigm is concerned with issues of identity and personal behavior (Pichardo, 1997). As Kauffman (1990) notes, identity itself is the fundamental focus of political work. Of importance is how activists conceptualize themselves, their worlds, and the external structures and dominant cultures in which they operate (Meyer, Whittier, & Robnett, 2002b). They draw on both dominant and oppositional cultures. Examples of New Social Movements include the animal rights, feminist, peace, and gay/lesbian movements.

New Social Movements are said to be a product of the postmaterial age (Pichardo, 1997). Developed initially in Europe to help explain new movements that emerged in the 1960s and 1970s for which class was not the organizing principle, new social movements place emphasis on collective identity. Unlike traditional Marxist-based movements, these movements are thought to organize through networks rather than through work-place orientation and are often associated with middle class membership (Searle-Chatterjee, 1999). Scott (1990) argues that New Social Movements are primarily social, emerge from civil society and focus on changing values and lifestyles. Concerned with rejecting the hegemony of the ruling class, new social movements do battle at the cultural level (Mooers & Sears, 1992). The emphasis is on quality of life and lifestyle concerns rather than economic redistribution (Pichardo, 1997). Structural inequalities, rather than economic ones, help to shape collective identity and movement culture.

According to Tarrow (1994), New Social Movements prefer to remain outside the normal political channels instead employing disruptive tactics and mobilizing public opinion. Within

the theoretical space of New Social Movements there is room for movements or movement groups that are externally oriented and seek to change social and cultural norms, practices and consciousness rather than political rights or policy changes (Koopmans, 1999). The target of new social movements is civic society rather than the state (Cohen, 1985).

One criticism of New Social Movement theory is that it ignores the role of government policy in creating causes and constituencies, and thus essentialize the potential identity of the individual and ignore human agency (Meyer, 2002b). A second critique is that these movements are seen as originating solely from the left and ignore conservative and counter movements (Pichardo, 1997). A third critique comes from the lack of minority participation in most New Social Movements (Pichardo, 1997).

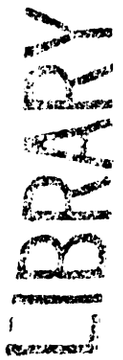
Framing

In sociology the concepts of framing have their historical roots in Berger and Luckmann (1966), Becker (1973), and Goffman's (1974) work. Frames represent the means by which individuals and groups come to recognize their worlds. Social movement scholars use framing processes to address the often ignored issue of meaning work, that is the struggle over the production and mobilization/countermobilization of ideas and meanings. The public deployment of frames and discourses for understanding issues is central to gaining recruits and bringing about change. In their review of framing processes and social movements, Benford and Snow (2000) point to a large body of literature to demonstrate how framing processes are now recognized as key tools for understanding social movements, alongside resource mobilization and political opportunity processes. For Staggenborg (2002) the notion of collective action framing is helpful in connecting the macro, meso and micro levels of analysis. Meyer (2002a)

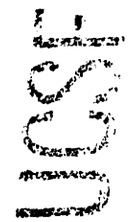
likewise argues that linkages among micro, meso, and macro levels are affected by identity, ideology and framing.

The use of the term "framing" denotes an active, processual phenomenon that implies agency and contention at the level of reality construction. The products of this framing activity are referred to as "collective action frames," which are seen as outcomes of negotiated shared meanings (Gamson, 1992 as cited in Benford & Snow, 2000). Collective action frames can vary in their many features which may include the means for problem identification, the flexibility and rigidity or inclusivity and exclusivity, the interpretive scope of influence, and the degree of resonance (Benford & Snow, 2000). There exist a set of generic or "master frames" that cut across socail movements. These include, but are not limited to, rights frames, injustice frames, pluralism frames, sexual frames, terrorism frames, hegemonic frames and "return to democracy" frames (Benford & Snow, 2000). These frames exist not only because they are applicable to multiple movements but because they are culturally resonant (Swart, 1995 as cited in Benford & Snow, 2000). The degree of frame resonance varies by the credibility of the proffered frame and its relative salience. The credibility of any framing is seen as a function of frame constituency, empirical credibility, and credibility of the frame claimsmaker (Benford & Snow, 2000). Relative salience to the targets of mobilization is affected by the centrality, the experiential commensurability, and the narrative fidelity. Centrality has to do with how essential the movement frames are to the lives of the targets of mobilization. The more central, the greater the probability for mobilization. Experiential commensurability asks whether the movement framings are congruent with the personal, everyday experiences of the target mobilization. Finally, narrative fidelity is the extent to which the framings culturally resonate with the target (Benford & Snow, 2000).

According to Benford and Snow (2000), collective action frames are constituted by "core framing tasks" which can be categorized into "diagnostic framing", "prognostic framing," and motivational framing." By pursuing these core framing tasks actors deal with the interrelated problems of "consensus mobilization" and "action mobilization." "Diagnostic framing" refers to problem identification and attribution. Recognizing that the goal of social movements is to alter a situation, the directed action is contingent on identification of the source(s) of causality or blame. Within social movements there are often controversies over this assignment of culpability. Often social movement work will refer to an "injustice frame" (Gamson, Croteau, Hoynes, & Sasson, 1992). Numerous studies have called attention to the ways in which movements identify the victims of injustice (Benford & Snow, 2000). Most recently theorists have called attention to the concept of "boundary framing" (Hunt, Benford, & Snow, 1994) and "adversarial framing" (Gamson, 1995) which seek to delineate the boundaries between "good" and "evil" or protagonists and antagonists.



"Prognostic Framing" involves the articulation of a proposed solution to the problem and the strategies to carry out the plan. It seeks to answer the issue of what is to be done. Of interest to social movement scholars are constraints resulting from existence within a multiorganizational field comprised of various social movement organizations, their opponents, targets of influence, media and bystanders. Case studies reveal that social movement organizations often differ from one another with regard to the prognostic dimension (Benford & Snow, 2000). "Motivational framing" is the rationale for engaging in ameliorative collective action. It includes the construction of appropriate vocabularies which provide adherents with compelling accounts for engaging in collective action and sustaining their participation (Benford & Snow, 2000).



According to Benford and Snow (2000) three overlapping processes are associated with the development, generation, and elaboration of collective action frames: discursive, strategic and contested. Discursive processes refer to the speech acts and written communications of movement members that occur in the context of movement activities. These may articulate, amplify or punctuate a frame. Strategic processes refer to the framing processes that are deliberative, utilitarian, and goal directed. These strategic efforts are usually conceptualized as four basic frame alignment processes (Snow, Rochford, Worden, & Benford, 1986): frame bridging (the linking of two of more ideologically congruent but structurally unconnected frames regarding a particular issue or problem), frame amplification (the idealization, embellishment, clarification, or invigoration of existing values and beliefs), frame extension (the depiction of frame as extending beyond the primary interest to include other issues presumed of importance to the potential adherence), and frame transformation (the changing of old meanings or the generation of new ones) (Benford & Snow, 2000).

Most scholars of social movements see the development, generation and elaboration of collective action frames as a contested process. Three forms of challenges confront those engaged in movement framing activities: counterframing by movement opponents, bystanders and the media; frame disputes within the movement; and the dialectic between frames and events (Benford & Snow, 2000). Counterframing often spawns reframing activities within and between movements resulting in what is referred to as "framing contests" (as cited in Benford & Snow, 2000; Ryan, 1991).

Naples (2002) contends that frames acquire meanings within external discourses and structural relations of race, class, and gender discourses and as such practices are structured and have real effects. To demonstrate her point she uses a materialist feminist discourse analysis to

show how progressive frames achieve wide acceptance, become institutionalized in social practice, and then lose their progressive intent. She focuses on the social and political contexts, subject positions, and power relations through which social movement frames are generated, circulated and then reinscribed within different discursive and institutional practices. She thereby reveals how movement frames reproduce particular relations of ruling and how existing discourses and power relations constrain the production of frames. She argues that those with greater power in the process of implementation can successfully gain control over the interpretation of the frame, and as such master frames can be incorporated into the wider political environment in ways that the originators did not intend. Thus, she concludes, framing studies must be sensitive to the dynamics of power within social movement organizations and across different arenas of social movements.

For Williams (2002) the irony of social movements is that to achieve their aims they must produce rhetorical packages that explain their claims within culturally legitimate boundaries. He articulates two critiques of the framing literature: a cognitive bias in understanding activism and a failure to recognize how framing is culturally constrained. He uses studies of the power of religion as a social movement force and religion rhetoric in social movements to demonstrated the limitations of the framing approach. Whittier (2002) argues that although scholars have been promising changes in framing analysis, considerable work remains to combine theories of meaning, e.g. discourse and collective identity, with a complex understanding of the state and political processes.

Steinberg (2002) contends that the incorporation of the concepts of framing within resource mobilization and the political process perspectives narrows the meaning of culture to something that is instrumental and deliberately produced. He criticizes framing studies for

assuming that meanings and understanding are conveyed through a discourse that is largely self-evident and unchanging. As a result, culture is seen as a thing apart from the complex ongoing processes of producing meaning during conflict. Frames, identities, and other cultural practices are therefore depicted as discrete, internally cohesive packages of meaning that pass between actors. Steinberg offers an alternative "dialogic" perspective in which discourse is seen as a relational process. Because challenges create oppositional discourses which borrow from each other, both the dominant and the challenging discourses mix together. In this way means, identities, and discourses convey meanings only between people in communication; discourse therefore is best perceived as a multivocal practice that is both enabling and constraining. As enabling, discourse gives the world meaning for action and provides opportunities to create new meanings that lead to new forms of challenge. But because actors cannot make meanings just as they wish, discursive practices limit the vision of what is necessary, plausible and justifiable. Most importantly dialogists find constraints in discursive practices of power and dominance (Burkitt, 1998; as cited in Steinberg, 2002:213). Thus in comparison to framing studies, dialogism offers a more relational and contingent analysis of cultural practices. As Steinberg (2002:213) writes: "Rather than looking for distinct frames or ideologies that challengers pit against dominant frames, or assuming that resistant cultural practices are harbored in a detached subversive subculture, dialogic analysis argues that much contention occurs within a discursive field heavily structured by the dominant genres."

Other Important Concepts in Social Movement Research

Social Movement Organizations

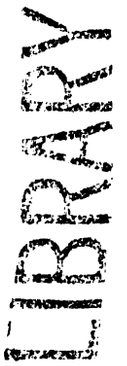
Social Movement Organizations has been a central cites of inquiry for social movement theorists for many years. Social movements are thought to manifest themselves through a wide

range of organizations which are subject to a range of internal and eternal pressures which affect their viability, their internal structure and processes and their ultimate success in attaining goals (Zald & Ash, 1966). A social movement organization is "a complex, or formal, organization which identifies its goals with the preferences of a social movement or a countermovement and attempts to implement those goals" (McCarthy & Zald, 1977:1218). Social movement organizations evolve through an inevitable processes of institutionalization and bureaucratization (McAdam, McCarthy, & Zald, 1996).

Since its original conceptualization in economic-related terms, theories of social movement organizations have undergone substantial theoretical development. Now understood within notions of meso-level analysis, social movement organizations are examined as mediating macro and micro conditions (Meyer, 2002a). New work incorporates activists' "standpoints," identities, and ideologies into the study of social movement organizations (Meyer, 2002a).

Questions about whether social movement organizations facilitate or deteriorate the potential for movement survival remains contested. McAdam, McCarthy, and Zald (1988) focus on the role of formal social movement organizations in maintaining movements whereas Piven and Cloward (1977) argue that movement organizations hasten movement decline (as cited in Staggenborg, 2002). Staggenborg (1988; , 1991) posits that stable social movement organizations are particularly important in the maintenance of movements that face countermovements. But, the need for stability within the social movement organizations has been challenged. Schwartz (2002) argues that rather than hurting movements, factionalism promotes continuity and may help movements survive. And while factionalism is thought to be more pronounced in less formalized collectivists groups, highly organized groups can also adapt to factionalism without destruction of movement organizations (Reger, 2002).

Existence of social movement organizations, however, are insufficient to explain maintenance of a social movement and studies of social movements should seek to understand the larger context in which the social movement organization is embedded. Social movement organizations are part of "social movement communities" comprised of both social movement organizations and the networks of individual movement adherents who do not necessarily belong to social movement organizations as well as institutionalized movement supporters, alternative institutions and cultural groups (Staggenborg, 2002). The whole complex of social movement organizations and communities can be thought of as a social movement industry. These industries are part of a social movement sector that address a diversity of issues (Blanchard, 1994).



Countermovements

Movements often create their own opposition, which sometimes takes the form of countermovements. A countermovement is a "set of opinions and beliefs in a population opposed to a social movement" (McCarthy & Zald, 1977:1218). For example, in the United States, movements and countermovements mobilized to promote and fight the Equal Rights Amendment, gay rights, gun control, busing, and abortion. Initially social movement theories viewed the countermovement phenomenon as essentially reactionary and directed more at the state and society than the precursor movement. Lo (1982) questioned this perspective, arguing that a countermovement may be either progressive or reactionary. Rather its defining characteristic is that it is dynamically engaged with and related to an oppositional movement. Once a countermovement is mobilized, movements and countermovements react to one another. In some instances a countermovement may in turn generate a counter-countermovement that is different from the original movement (Zald & Useem, 1987).

For Meyer and Staggenborg, (1996) this linear image of movement-countermovement combat is insufficient to explain social movement phenomena. They argue for understanding these initiating and responding movements as opposing movements comprised of networks of individuals and organizations. In this conception, opposing movements influence each other both directly and by altering the environment in which each side operated. Thus, using a dynamic and integrationist model of political opportunity Meyer and Staggenborg (1996) view opposing movements as rival contenders for power and influence as well as for the primacy of identifying the relevant issues and actors.

Meyer and Staggenborg (1996) argue that three conditions promote the rise of countermovements: 1) signs of success by the movement; 2) a threat for a population from the movement's goals, and 3) political allies to aid oppositional mobilization. There is a curvilinear relationship between movement success and countermovement emergence. When movement issues are seen as symbolizing a larger set of values and behaviors, they are likely to attract a broad range of constituencies to the countermovement. That is, the greater the oppositions' ability to portray the conflict as one reflecting larger value cleavages in society, the greater likelihood that opposition will become a sustained countermovement (Meyer & Staggenborg, 1996). The media also plays an important role in the production of countermovements as journalists seek out opposing interests in response to movement claims (Meyer & Staggenborg, 1996).

Ideology

Theories of ideology are addressed in Chapter 2. In his new work, Zald (2000) suggest that social movements should be conceptualized as "ideologically structured action." Such an approach allows for the incorporation of cultural/cognitive components of action into core

definitions. It also allows for a deeper understanding of socialization to social movement ideology and to social movement-related action that takes place in a variety of institutional arenas. Benford and Snow (2000) clarify that while there is a relationship between frames and ideology, they are not one and the same. Rather ideologies function both as a constraint and resource in relation to the framing processes (see also Oliver & Johnson, 2000; Snow & Benford, 2000).

Williams and Blackburn (1996) argue that every movement must go through a translation process whereby the "formal ideology" of the movement leaders becomes the "operative ideology." Because they need to engage in the public sphere through the mass media they must produce a public discourse that defines their purposes in generally legitimate language (Williams, 2002).

Tactics and Outcomes

Analysis of social movements also includes attention to the use of tactics, both how they are chosen and how tactics produce effects, illuminating the interplay of tactics, organizational form, ideology, and political leadership (Meyer, 2002b). Staggenborg (2002) argues that movement "campaigns" play a critical role and thus are one fruitful avenue of inquiry. Another strategy for explaining how social movements promote change examines the effects and characteristics of movement action or protest events such as riots, demonstration, boycotts, and other public action (Andrews, 2002). There is substantial disagreement about what makes protests influential with the causal mechanism tending to be either disruption-threat or persuasion-sympathy. For Piven and Cloward (1977) the most useful way of thinking about the effectiveness of protest is to examine the disruptive effects on institutions and the political reverberations of those disruptions For others such as Lipsky (1968) the role or protests is to

activate third parties to enter the bargaining arena in ways favorable to the protesters. Activation of the bystander public and the conscience constitutes are critical in models of explanation based on persuasion-sympathy. For Andrews (2002) there is an important interaction between movement organizations and protest events which also must be explored.

Maheu (1995), however, argues against seeing movements simply as concrete collective actors and advocates for moving beyond movement-centered analyses and thereby seeing collective action as inherently dialogical bringing together systems and actors. In this way he supports a paradigm of collective action that underscores relationships between agency and structures of domination. Thus, the larger question of "what to do" has implications for the larger debate between agency and structure. Similarly, Whittier (2002) argues that the forms of collective action in which activists engage, the frames they issue, the targets they address emerge from the intersection of structures and meanings, both within and outside the movement.

Although "opportunities," "resources," and mobilizing structures affect what movement actors do, they matter only to the degree that actors recognize them and employ them. As such these factors possess an inherent interpretive aspect that must be socially constructed to be activated. Thus, different movements, and different factions within the same movement adopt different strategies under similar external circumstances.

A challenge for social movement scholars is deciding what counts as an outcome or consequence of a social movement (Andrews, 2002). Often scholars focus on the successes of a movement failing to pay attention to the unintended impact of a movements' effects. Andrews (2002) argues that instead of limiting the analysis to the intended outcomes of the movement, analyses of social movements should focus on as many outcomes as possible, whether they are

political, social, economic or cultural. For Andrews (2002) the question is not whether movements have an impact but how they have one.

The Role of Gender

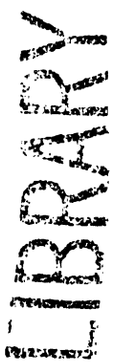
Feminist scholars argue for using a gender lens in the study of social movements. Such a demand rests on the assumption that gender is a basic organizing principle in human society and that gender roles, relations, and inequalities impact social processes in complex ways (Kuumba, 2001). A gender lens places emphasis on gender differentiation in the broader social structures including economies and political systems and the way in which both culture and meaning are gendered.

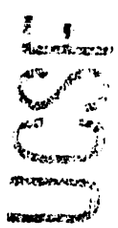
The initial efforts in gendering the analysis of social movements sought to reduce the invisibility of women, what Kuumba refers to as the "sex role" stage of gendering social movements. This approach was criticized for essentializing the categories of women and men, creating a monolithic reality. The limitations of this approach led scholars to acknowledge the broader effects of gender as a system of relational inequities and its impact on resistance and protest. Like many other structures, gender can both inhibit and catalyze action. Gender affects social movement recruitment and mobilization, roles assumed, activities performed, resistance strategies, organizational structures and the relevance and impact of movement outcomes.

Within the theories of political process, gender theorists argue that research must address "the ways in which institutionalized gender ideologies interact with larger social conditions to mediate the perception and definition of political opportunities" (Kuumba, 2001:52). A gender lens challenges the resource mobilization theoretical perspective's focus on official institutions, structures, and tangible resources (Buechler, 1993; as cited in Kuumba, 2001:54) as well as its emphasis on the rational actor as dichotomously posed against emotion and other subjectivities

such as gender ideologies (Ferree & Miller, 1985; as cited in Kuumba, 2001:54). As such, research must pay attention to both informal networks and resistance of actors to formalized structures. A gender lens also calls for addressing the bias against emotional/nonrational basis for action.

While New Social Movement theories of collective identity and collective action frames afford more opportunity for gendered analysis they are also limited by failure to address gender as a structure. One of the most potent manifestations of gender is the "maternal frame" which by centering on women's activism within the cultural themes and language of mothering (Kuumba, 2001) often reifies an essentialist interpretation of women in social movements. An intersectional analysis, by comparison, contends that movement participants often occupy several locations simultaneously, what Wright (1997) calls contradictory structural location. Kuumba (2001) calls for an emergent social movement theory framework from the standpoint of women within particular social context and in concert with race, ethnicity, culture and class.





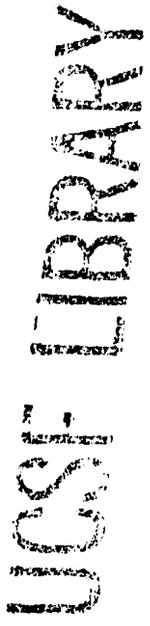
Health Social Movements

Brown and colleagues (2004) argue that while social movements organized around health issues have long been studied, they have received little theoretical attention by scholars of social movements. For Brown et al, Health Social Movements can be subdivided into three categories: First, *health access movements* seek equitable access to health care and improved provision of health services. Second, *constituency-based health movements* address health inequities and inequity based on race, ethnicity, gender, class, and/or sexuality. Third, *embodied health movements* address disease, illness experiences, or disability, and contested illness by challenging science on etiology, diagnosis, treatment and prevention. This typology represents ideal types and allows for overlap and variation within and across categories. Within movements

there exists a strategy and agenda continuum. At one end are advocacy-oriented social movement organizations that work within the existing system and biomedical model, use non-direct tactics, and tend not to push for lay knowledge to be inserted into expert knowledge systems. At the other end of the continuum are activist-oriented groups engaged in direct action, challenging scientific and medical paradigms and pursing participating in scientific and policy knowledge production.

The claim for greater access to health care is not new and has often focused on struggles with managed care organizations, insurers and the state (Waitzkin, 2001). These struggles are now studied as social movements, integrating theories of resource mobilization, political process opportunities, cultural framing, and new social movements (Brown et al., 2004). As Brown and colleagues explain, the limitations of each of these approaches separately are identifiable through an understanding of health social movements. Resource mobilization downplays the importance of grievance, a critical factor in the formation of health social movements. Likewise, the political opportunity approach can not address the reality that health needs are immediate and therefore those organizing do not have the luxury of waiting for ripe political opportunities, and consequently advocates often organize despite political constraints. While framing analysis helps to explain how illness experience is transformed from personal problem to social problem it is less able to explain how social movement organizations can be successful at recruiting followers and supporters who do not have the particular condition that defines the organization. New Social Movement theory brings culture to the fore offering the capacity to discuss contested knowledges. However, its failure to see class as a salient feature makes it inadequate to individually explain health social movements (Brown et al., 2004).

As a component of their work on health social movements, Brown and colleagues have developed a theoretical understanding of "embodied health social movements." Embodied health social movements are unique in that they: introduce the biological body to social movements, include challenges to existing medical/scientific knowledge and practice, and involve activities collaborating with scientists and health professionals in pursing treatment, prevention, research and expanded funding. Of importance is how identity represents the intersection of social constructionist of illness and the personal illness experience of a biological disease process, often reflecting a lived perspective that is unavailable to others. In their work, Brown and colleagues draws from the body of work on collective identity (F. Polletta & Jasper, 2001) and oppositional consciousness (Groch, 1994; Mansbridge & Morris, 2001) to develop the idea of "politicized collective illness identity," which transforms a personal trouble into a social problem. In this approach a collective illness identity is linked to a broader social critique of structural inequities and uneven distribution of social power which are identified as the causes and/or triggers of the disease. Brown and colleagues seek to theorize about the embodied health movements through the study of the environmental breast cancer movement. For Brown et al, embodied health movements are boundary movements, engaging both boundary work and utilizing boundary objects. They reconstruct the lines that demarcate science from non-science and good science from bad science. Of importance is that these movements cross boundaries with non-social movement institutions.

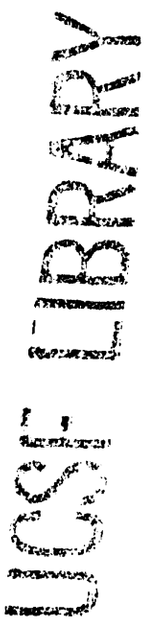


Summary and Implications for Studying Abortion

This chapter reviews both the tenets and the major critiques of the four theoretical traditions of social movement scholarship, resource mobilization, political process, framing and New Social Movements. It highlights the tension between those scholars that focus on structures

and those that privilege culture. It does not seek to resolve these theoretical debates but rather highlights various aspects of the theories that provide useful tools for examining the field of abortion opposition and support. Concepts of social movement organizations, countermovements, ideology, tactics and outcomes are reviewed. Justifications for using a gender lens and for examining health social movements are also provided.

The application of these theoretical concepts to the field of abortion is taken up at length in the subsequent chapters on the Pro-Life and the Pro-Choice social movements. In addition, theories are used to help understand how physicians became engaged in the early social movement efforts to reform abortion laws prior to legalization. Meyer (2002b) sets out several of the current challenges to social movement research that the analysis in this paper seeks to meet: 1) the need for multilevel analysis; 2) the need to link notions of identity to an analysis of the political process; 3) the need for cross-disciplinary boundaries (e.g. the work of historians, political scientists, anthropologists, and psychologists as well as sociologists); 4) the need to examine multiple movements in the same analysis; 5) attention to the concrete policy dimensions of political protest; and 6) concern for the relevance of the work undertaken to the values that animate social movements.



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Section II: Sociopolitical History of Abortion

CHAPTER 3: BRINGING ABORTION UNDER MEDICINE'S CONTROL (1850-1960)

This chapter traces the history of abortion from its unregulated and common status at the beginning of the nineteenth century through its complete criminalization by 1900 and the resulting construction of a new type of "therapeutic abortion" which became problematic in the mid 20th century. In particular it examines how abortion served as a central component of the effort to professionalize medicine during the mid 1800s. Theories of professionalism are briefly described to help the reader understand the power that medicine acquired as a result of its engagement with the issue of abortion and the extent to which the control it gained over abortion subsequently threatened that solidarity. The anti-abortion discourses produced during the professionalizing period are understood as ideologies that instantiate and perpetuate a hegemony of race/class/gender relations legitimized by medical knowledges. Both structure and culture are examined as explanations for social movement action. In particular, the relationship between physicians and the state with regard to abortion is reviewed. By exploring how anti-abortion became identity for physicians and how opposition was framed as social good further engages this discussion with social movement theories. Addition concepts from the field of social movement research including resources, social movement organizations, counter movements, tactics, outcomes also help to inform the discussion. The gendered nature of what happened to abortion during this period is highlighted in detail in this chapter.

Abortion as Common Practice in Early America

When the U.S. federal constitution was adopted abortion was known and was not illegal (281 American Historians, 1988). According to Mohr (1978), at the beginning of the nineteenth century there were no laws in the United States regulating abortion, as it was a common and accepted practice. Through the first decades of the nineteenth century, abortion only became problematic after "quickening." Quickening is the feeling of fetal movement.[1] English common law did not consider abortion before quickening a crime and abortion after quickening was considered only a misdemeanor. The criminality of abortion lay in the danger it posed to women's health rather than any recognition of the status of the fetus (Smith-Rosenberg, 1985) "The upshot was that American women in 1800 were legally free to attempt to terminate a condition that might turn out to have been a pregnancy until the existence of that pregnancy was incontrovertibly confirmed by the perception of fetal movement" (Mohr, 1978:4). That is, a pregnancy did not exist until a woman defined it as such.

Information regarding various drugs, potions, and techniques for abortion was available from home medical guides, health books for women, midwives and irregular practitioners, as well as from trained physicians (Mohr, 1978).[2] In addition the newly emerging urban newspapers found abortion-related advertisement a lucrative source of income and by the 1840s and 1850s, ads for abortifacients filled their pages (Smith-

[1] Quickening occurs when a pregnant woman feels the first movement of her fetus; ironically, a condition, which only the woman can define.

[2] Riddle (1997) has traced many of the products used at this time to a long history of use across the world. He argues that the era of criminalization of abortion in the United States successfully suppressed this knowledge such that information about these safe methods of abortion was not available when legalization of abortion occurred 100 years later.

Rosenberg, 1985).[3] The most famous abortionist of the era, Madame Restell of New York City, was said to have branch offices in two other cities and an advertising budget of $60,000 in 1861 (Tone, 1997).[4] Abortion was not, however, completely commercialized as use of folk remedies was also common (Gordon, 2002).

Efforts to control abortion began to surface in the early to mid 1800s. Between 1821 and 1841, ten states and one territory enacted legislation to make some abortions illegal (Sheeran, 1987). These laws were justified in the name of women's health and the earliest laws dealt with a specific type of abortion, poison, and did not generally proscribe abortion (Mohr, 1978). Poison, as a method of abortion, was through to be unsafe due to the threat of death, and consistent with history, the law only applied after quickening. In the language of the law "abortion" was synonymous with miscarriage and "criminal abortion" referred to abortion after quickening.

Medicine's Opposition to Abortion

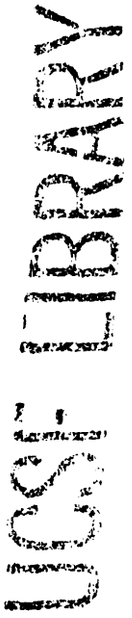
In the mid-eighteenth century efforts were undertaken to expand abortion prohibition to include all forms of surgical and medicinal abortion at all times in pregnancy. Though a number of groups participated in early criminalization campaigns, physicians are considered the leading force (281 American Historians, 1988; Luker, 1984; Mohr, 1978:22; Petchesky, 1984; Smith-Rosenberg, 1985)[5] The participation of

[3] Urban newspapers were also used to garner public support for abortion opposition as they transformed abortion into a scare issue, running sensationalist stories about disappearing wives and dismembered patients, in an effort to increase circulation (Smith-Rosenberg, 1985).
[4] Smith-Rosenberg (1985) argues that this highly commercialized nature of abortion is one of the contributing factors in the drive to make abortion illegal.
[5] Condit (1990) argues that the current emphasis on doctors is over-stated, arguing instead for the inclusion of more factors including the public discourse of the time.

physicians in these anti-abortion efforts reflects a complex interaction of the professionalization of medicine as well as power, ideology, and hegemony.

Professionalization of Medicine

Starr (1982) argues that the problem of professional sovereignty in American Medicine is historical; understanding it requires identifying the ways in which people acted, pursuing their interests and ideals under definite conditions, to bring the structure into existence. This section explores both the overall professionalization of medicine during this time as well as the unique contribution that abortion opposition played in this process.



Theories of Professionalism

Friedson (2001) provides the best theory of professionalism, what he names "the third logic." "Professionalism" is used to refer to the institutional circumstances in which members of occupations rather than consumers or managers control work. "Professionalism may be said to exist when an organized occupation gains the power to determine who is qualified to perform a defined set of tasks, to prevent all others from performing that work, and to control the criteria by which to evaluate performance" (:12). Professionalism can not exist unless it is believed that the task professionals perform is so different from that of most workers that self control is essential.

Through his work Freidson seeks to make the logic of professionalism enjoy the same privileged intellectual status as the logics of the market and the state. The goal is to recognize occupations as a basic political, economic and social category. He directly challenges those advocates of market and bureaucratic management who treat professionalism as an aberration rather than something with a logic and an integrity of its

own. In his work, Freidson develops what he calls the ideal type of professionalism as a method for conceptualizing and organizing the abstract theoretical issues and the practical social policy issues which confront scholars seeking to understand work. Central to ideal type of a profession is monopoly and in that the freedom of judgment or discretion in performing work. This worker-controlled labor market has the exclusive right to determine the qualification for particular jobs and the nature of the tasks performed. Their professional jurisdiction can be the result of negotiations or unilaterally established by the state. In the latter case the consumer is obligated to employ only those qualified by the occupation. Lastly, Freidson argues that ideologies of professionalism are the primary tools available for gaining political and economic resources needed to establish and maintain status. While there are many issues embedded in those ideologies, one of the most fundamental is the meaning and purpose of the work and those who perform it. Thus the ideological core of professionalism is the claim to a discretionary specialization, or the employment of a body of knowledge that is only gained through specialized training.

Medicine has long been considered the prototypical profession (Freidson, 1970a, , 1970b). According to Starr (1982), the rise of the medical profession depended on the growth of its authority. There are two types of authority, social and cultural, which differ in important ways. Social authority, articulated by Weber (1968 [1922]) as legal authority, involves the control of action through the giving of commands. Cultural authority "refers to the probability that particular definitions of reality and judgments of meaning and value will prevail as valid and true...It entails the construction of reality through definitions of fact and value" (:13). Freidson (1970a) argues that the status of the

profession allows it to shape the official recognition and certification of need for services as well as the way that need will be organized by the service it controls. Starr (1982) concurs when he acknowledges that the profession has been able to turn its cultural authority into social privilege, economic power, and political influence.

Medicine as a Profession

Colonial American medicine was largely self-help; most American physicians were barely educated and trained by apprenticeship and most were undifferentiated practitioners. There were a small number of elite physicians who were trained under the European model which consisted of formal academic training. These elite, or "regular physicians" as they were called, practiced predominately in cities, and had minimal political power although they had high social status. Around 1800, these regular physicians convinced state legislatures to pass laws limiting the practice of medicine to practitioners of a certain training and class. Most of these laws were ineffective and were repealed during the Jacksonian period (1828-1836) (Starr, 1982).

Between 1840 and 1870, new external factors severely challenged the medical profession's elites; factors that would ultimately inform the profession's anti-abortion position (Smith-Rosenberg, 1985). As commercial and transportation revolutions disrupted East Coast agriculture and village life, young men from farms sought new means of securing an income, turning to the practice of medicine. New schools opened to provide quick education in the field of medicine. These new physicians sought opportunities in growing urban cities. At the same time that the number of physicians was increasing, a host of medical-reform movements including herbalism and homeopathy, began to challenge medical orthodoxy. These reformers established a

number of alternative medical schools and hospitals (Smith-Rosenberg, 1985) and produced numerous providers who competed for female patients with both regular and apprentice-trained physicians as well as midwives.

By 1940 the prolific expansion in the number of unregulated medical schools and physicians had given medicine in the United States a bad reputation (Tone, 1997). Concerned about this denigration of their profession well-connected physicians began a struggle to upgrade standards within the medical profession. To gain political support for their efforts and to correct the poor image of medicine, a group of regular physicians founded the American Medical Association (AMA) in 1847 to promote the science and art of medicine in the promotion of public health. The AMA was the crux of the regulars attempt to "professionalize" medicine (Conrad & Schneider, 1997). The AMA was ultimately successful in raising the status of the medical profession, in large part due to its primary role in opposition to abortion (Mohr, 1978), which is discussed in detail below in the section "The Professionalization of Medicine through Opposition to Abortion."

Regular physicians also founded state and local medical societies and placed great emphasis on specialization. Lobbying efforts were undertaken to make medical school attendance and clinical training prerequisites for licensing (Tone, 1997). Reform of medical education was seen as a critical step in legitimizing the profession of medicine by creating a system to reproduce authority from one generation to the next and to transmit from the profession as a whole to all its individual members (Starr, 1982). Reform began in the 1870s with the affiliation of medical schools with universities (Shi & Singh, 2001). The most radical changes in medical education occurred when Johns

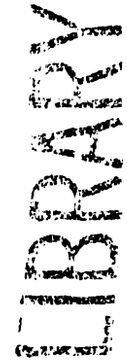
Hopkins opened its medical school in 1893 creating a new relationship between science and research (Starr, 1982). For the first time medical education became a graduate training course requiring a college degree as an entrance requirement (Shi & Singh, 2001). The Association of American Medical Colleges (AAMC), founded in 1876, later set minimum standards for medical education based in part on the Johns Hopkins model of medical education (Shi & Singh, 2001). Once advanced graduate education became an integral part of medical training, it helped legitimize the profession's authority and galvanize its sovereignty (Shi & Singh, 2001).[6]

In addition to consolidating its power and authority through professionalization and the control over medical education, the profession of medicine continued to push the issue of licensing. Unlike law, medicine had no long-standing or intimate relationship with state legislators and no strong tradition of licensing regulations (Starr, 1982). Under the Medical Practice Acts established in 1870s, medical licensure in the United States became a function of the states. It can be argued that "the early licensing laws did not so much protect consumers as they protected practitioners from the competitive pressures posed by potential new entrants into the medical profession" (Shi & Singh, 2001:89). Unlike prior failed licensing attempts, these second efforts were rewarded with legitimacy. The states promoted the dominance of the physician when they made it illegal for other workers to compete with physicians and gave physicians the right to direct the activities of related occupations. As Starr (1982:22) explains, "standardization

[6] The medical monopoly was further enhanced by the 1910 Flexner Report on medical education that urged stricter state laws, rigid standards for medical education, and more rigorous examinations for certification to practice. The enactment of the Flexner Report's recommendations created a near total AMA monopoly of medical education in America (Conrad & Schneider, 1997).

of training and licensing became the means for realizing both the search for authority and control of the market."

Not all individuals, however, had the same access to entrance into the profession of medicine. Formalization meant the increase control over healthcare by those from wealthy elite segments of society who had access to the educational institutions where attendance was now required. Thus in consolidating power through the mandating of graduate education and in securing licensure requirements, the profession of medicine became unattainable to many, and the social power of medicine was maintained within the elite classes. This consolidation is a critical component of the way in which abortion would be articulated as an issue for society, as discussed later in this chapter.



The Professionalization of Medicine through Opposition to Abortion

The AMA made the criminalization of abortion one of its highest priorities (Mohr, 1978). In 1857, the AMA initiated a formal investigation of the frequency of abortion; seven years later it would offered a prize for the best physician antiabortion effort. By the 1870s both professional and popular journals were virtually saturated with the issue, in large part due to the AMA's intense campaign against abortion (Gordon, 2002). Medicine's vehement opposition to abortion was not based on moral objections to abortion, but rather because the issue served so well as the center of the new organization's professionalizing project (Starr, 1982). In opposing abortion the medical profession saw an opportunity to distinguish itself from other non-physician health care. Because abortion provision in the 19th century drew so heavily on nurses, midwives, and other "irregular" health care providers, mobilization around this issue provided a highly suitable vehicle to differentiate regular physicians from the wide variety of other groups

also making claims to be legitimate health care providers in that period (Luker, 1984; Mohr, 1978). These regular physicians were especially anxious to replace midwives who had until that time been the main source of assistance to women giving birth or seeking abortions (Rubin, 1998; Wertz & Wertz, 1989). By repressing abortion, the AMA could restrict the demand for health care provided by nonphysicians (McFarlane & Meier, 2001). Riddle (1997) further argues that another reason for the opposition to abortion and birth control was that the physician could not necessarily just take the place of the midwife or herbalist as he had no formal training in the materials used for these matters. As Kapparis (2002) notes, the desire for physicians to distinguish themselves from other medical craftsmen dates to early modern times. However, the period of the mid-1800's, through engaging in efforts to criminalize abortion, afforded the medical profession a historical opportunity to make this distinction permanent and thereby complete the process of professionalism.

Many regular doctors believed strongly that their future depended on rigorous professionalization that was dependent in large part upon the ability of the group as a whole to enforce standards of behavior on individuals who wanted to be part of the profession (Mohr, 1978). Since some regular physicians performed abortions differentiation with other practitioners required getting these physicians to stop doing abortions. As such "the rhetoric of professionalism was striking and obvious in the anti-abortion crusade from 1860-1880" (Mohr, 1978:162). As Freidson (1970a, 1970b) notes, having a standard set of norms and behaviors is a defining characteristic of a "profession." An anti-abortion law lent public sanction to the professionals' efforts at disciplining their own organization's members. Unmitigated scorn was targeted at those

regular physicians who performed abortions. "By the end of the century, about the worst charge one doctor could make against another was that of taking part in an abortion" (Hull & Hoffer, 2001:30). This antipathy toward the physician abortionist would be a permanent part of the relationship of medicine to abortion provision; the implications of which are discussed at length in Joffe's (1995) work which examines the marginalization of physicians who performed abortion before and after *Roe v. Wade*.

Regular physicians also made their adherence to the Hippocratic oath central to the distinction between themselves and other practitioners (Smith-Rosenberg, 1985). According to the translation used by physicians at the time, the oath contained a specific reference to abortion: "I will give no deadly drug to any, though it be asked of me, and I will not counsel such, and especially I will not aid a woman to procure abortion" [The Hippocratic Oath, Hippocrates of Cos, B.C. 460].[7] Thus under the aegis of the prohibition of abortion by their sacred oath, regular physicians could deny abortion to requesting patients (Smith-Rosenberg, 1985) and prohibit abortion within its ranks.

Hull and Hoffer (2001) take a more charitable view of the anti-abortion efforts of the nineteen century. While they admit that motivations to compete with growing number of nonphysicians were part of the reason for physicians' anti-abortion stance, Hull and Hoffer posit that many physicians were motivated by concern about the welfare

[7] One issue that has baffled historians of medicine is the extent to which the opposition to abortion is a central a component of the Hippocratic Oath. In *Roe v Wade* the Court recognized differences in translation of the oath some of which only include prohibitions of specific types of abortion. After detailed review of the Oath, Edelstein (1943) has argued that the anti-abortion perspective is reflective of a marginal Pythagorean sect, to which Hippocrates belonged, rather than the mainstream medical culture of the time. However, current scholars including Lichtenthaeler (1984) and Kapparis (2002) find evidence to support the acceptance of a mainstream medical opposition to abortion at the time the Oath was written. This debate need not be resolved for the purposes of this paper. Rather what is of relevant is that at the time of criminalization of abortion in the United States, the profession of medicine interpreted the Hippocratic oath as hostile to abortion.

of their patients who were being treated outside mainstream medicine. These physicians often treated the effects of abortions that went wrong. (Hull & Hoffer, 2001). Professionalism can thus be seen as grounded in concern for the welfare of patients. Such a view however ignores the reality that the alternative to abortion, childbirth, was also extremely risky for women at this time in history and many more women died in the process of childbirth than abortion. In fact, Mohr (1978) argues that abortion was relatively safe by the medical standards of the day.

Abortion Opposition as Power, Ideology, and Hegemony

The anti-abortion campaign of the late 1850's coincides with changes in domestic and social relations and thus it must be understood against a gendered backdrop (Tone, 1997), involving a virulent condemnation of women's reproductive anatomy (Hull & Hoffer, 2001). As the medical profession acquired greater stature it reified and inflated the social significance of biological differences. This confluence of reproductive ideologies assumed the inherent weakness of all women, whose emotional and mental faculties could not stand the demands of modern public life (Hull & Hoffer, 2001). Thomson (1995) argues that the medical campaign against abortion occurs within a context of notions of biopower as medical knowledge of reproductive organs became a disciplinary power. Stormer (2002) further articulates the existence of fears about the body politic and thus locates opposition to abortion within the complex weave of race, class, and sexuality that textures "biopower." Abortion thus is both the product of a set of race/class/gender relations and is the means to maintain these relations.

This section reviews how medical knowledge became disciplining power specifically through opposition to abortion. Also addressed is how abortion opposition

reflects race, class, and gender ideologies and how these created a new hegemonic understanding of reproduction. To assist in understanding these positions, a brief discussion is provided of medicine as disciplining power.

Abortion Opposition as Biopower

The deep involvement of doctors in early opposition to abortion can also be understood as a struggle between the proponents of "scientific medicine" and those that practices other forms of healing (281 American Historians, 1988). When the AMA officially declared war on abortion its manifesto spoke in the language of knowledge and truth. The AMA "Report on Criminal Abortion" listed three causes for the rate of abortion: general ignorance, lack of proper training among regulars, and laws based on "mistaken and exploded medical dogmas" (as quoted in Stormer, 2002:35). To substantiate this claim, regular physicians had to constitute the practices that would reify the knowledge that would make them credible. In the opposition to abortion, the difference between what counted as knowledge and as ignorance separated regular physicians from abortionists. Any medical practitioner who supported abortion was by definition a quack. Thus to not be considered ignorant, physicians needed both to stop doing abortions and to oppose abortion (Stormer, 2002).

Imber (1990) argues that abortion was not simply a convenient target for regulation but an inevitable one. He distinguishes between the use of professional power to control abortion and the definition of abortion as morally problematic as central to the creation of physician authority. In this way he criticizes other authors for their primary focus on market formation and professional dominance rather than on the factors distinctive to the medical practice itself. Stormer (2002) develops a theory to further this

perspective. His work investigates the performative nature of medical practice. Foucault (1980) called the set of discourses and practices used to control individual bodies and health "biopower." Thomson (1995:162) uses biopower to mean "the move to regulate and mange the movements, passions, and reproduction of populations." Filc (2004) argues that the unequal distribution of power in contemporary society is reflected and reproduced in medical ideology. Thus when the practices and ideologies of medicine are used to validate anti-abortion as a form of knowledge, abortion opposition can be understood as biopower. As Foucault (2000:137) argues "The body is a biopolitical reality; medicine is a biopolitical strategy." Thus, biopower is produced and reproduced through medicine, both as a discourse and as a practice.

Foucault writes that during the eighteen century, power shifted from the ability to control life through death to the management of life. Through medical practices emerged an understanding of life as a rational mechanical force within the body. This notion of managing this life permeates early opposition to abortion (Stormer, 2002). Adams (1994:136-137) puts Foucault's work in the abortion context "Instead of focusing on the moment of death as the revelatory moment, now the clinical gaze focuses on the first moments of life...In its search for the root of life, the clinical gaze shifts from the corpse to the living embryo". The recognition of the fetus as life would be a critical component of the future abortion debate and in particular the role that the state would play. Where early opposition to abortion was grounded in protecting women from themselves and in recognition of physician authority, *Roe v. Wade* would later recognize the state's compelling interest in protecting the life of the fetus; a direct consequence of this shift to equating abortion, the fetus, and life.

Abortion Opposition as Gendered Ideology

Smith-Rosenberg (1985) contends that because obstetricians and gynecologists dealt with matters of women's biology they suffered from low professional status and thus the need to be identified as men of science made them particularly invested in controlling both the care and the behavior of women. As the science of obstetrics developed, emphasis was placed on anatomy and physiology (Leavitt, 1983) and women were increasingly depicted as captives of their reproductive organs (Tone, 1997). Throughout the medical literature of the time women who aborted were portrayed as unconscious and unable to understand what they were doing (Stormer, 2002). One of the most outspoken proponents of this perspective was Horatio Robinson Storer, MD, who led the AMA effort as the chair of the AMA Committee on Criminal Abortion. In 1866 Dr. Storer won a prize from the AMA for his essay *Why Not? A Book for Every Woman*, designed to enlighten society about the evils of abortion. In his book he explains why women should not be allowed to make decisions about their health since their biology precludes them from making rational decisions:

> "If each woman were allowed to judge for herself in this matter, her decision upon the abstract question would be too sure to be warped by personal considerations, and those of the moment: Woman's mind is prone to depression, and, indeed, to temporary actual derangement, under the stimulus of uterine excitation..."(Storer, 1866)

Stormer (2002) argues that physicians were articulating the use of abortion in the language of lost memory. That is, women were becoming dissociated from their inner, true selves and it was physicians' role to reeducate women about their womanly essence and their place in the reproductive scheme of culture. As a result of their ignorance of their own bodies women had lost touch with their natural maternal instinct. The cause of

this loss of memory was modern society; thus abortion represented a corruption of civilization. It was, therefore, up to physicians, to locate the memory. They did this by controlling the examination of the female body through a set of medical practices that could reveal the truth. Through the practices of physicians' examination[8] the female body made somatic confessions about the naturalness of pregnancy and thus the unnaturalness of abortion. As Stormer (2002:145) explains: "Through the metonymic and chiastic functions of body criticism, female organs and cycles were imbued with an organic discourse that only physicians could translate from spectacle to speech." Thus medical anti-abortion discourse was the articulation of what the natural body was supposed to do (Stormer, 2002).

Smith-Rosenberg (1985:235) argues that understanding the professional needs of the AMA and regular physicians is insufficient to explain the anti-abortion movement's imagery and rhetoric and "to understand these aspects of the movement, we must unravel the psychological and semantic exchanges that occurred between the medical profession and the general male public." As many regular physicians were among the most defensive groups in the country on the subject of changing sex roles (Mohr, 1978), medicine's response to abortion was also motivated by a desire to maintain existing gender roles (Thomson, 1995) To many doctors the chief purpose of women was to have children and abortion interfered with that role (Mohr, 1978).

The physicians' campaign, however, represented a gender as well as class and ethnic conflict (Petchesky, 1990). It was aimed first at the redomestication of married WASP women, who made up the physicians' primary clientele. At the same time, it was

[8] At this time the speculum became the primary tool for investigation into women's reproductive ailments as physician examination grew in popularity within ob/gyn (Stormer, 2002).

aimed at the defense of the WASP establishment against rising immigration and proletarianization. As Petchesky (1990:83) explains: "[S]exual conservatism, professional elitism and aggrandizement, and class and race bias entwined to determine the unique role of medical professionals in formulating a state policy criminalizing abortion in the nineteenth century."

The physician campaign against abortion should, therefore, be understood within the context of declining fertility rates during the mid-nineteenth century (Tone, 1997). In the early 1840's the demographic profile of the aborting woman changed dramatically as more white, married, Protestant, middle and upper class women began using abortion to space and limit the number of children they had. As a result the overall incidence of abortion rose sharply to an estimated one abortion for ever five or six births (Mohr, 1978). Between 1800 and 1900 the white fertility rate in the US decreased by fifty percent and the number of children born to married women decreased from 7.04 in 1800 to 6.14 in 1840 to 4.24 in 1880 and finally to 3.56 in 1900 (Smith, 1973). These changes were understood as the product of abortion and consequently, anti-abortion messages included apocalyptic warnings of race-suicide (Thomson, 1995). The woman's womb, therefore, carried the fate of an entire class, ethnicity, race and nation (Stormer, 2002). Storer (1866:84-85) promoted this in the public dialogue of the day:

> Shall [the great territories of the far West] be filled by our own children or by those of aliens? This is a question that our own women must answer; upon their loins depends the future destiny of the nation.

The incidence of abortion was seen to reflect a growing self-indulgence on the part of the county's women (Thomson, 1995:179). As Smith-Rosenberg (1985:238) explains: "Bourgeois women, by selfishly curtailing the birth-rate, doctors and

sensationalist journalists alike argued, had precipitated a national crisis and a national scandal. For example, Nebinger (1876:11) believed that women sought abortions mainly "to avoid the labor and expense of raising children, and the interference with pleasurable pursuits, fashions and frivolities" (as quoted in Thomson, 1995:179).[9] The aborting wife was portrayed as urbane and affluent, threatening both the social order and the future of the race. She was motivated completely out of desire to avoid family responsibilities and to assume new non-domestic roles (Smith-Rosenberg, 1985). This image of the willfully aborting bourgeois woman helped convince the male bourgeois public and male politicians that abortion constituted a threat to social order and male authority (Smith-Rosenberg, 1985). The solution was the intervention of the male state and the profession of medicine which needed to regulate women's bodies in order to save the future race (Smith-Rosenberg, 1985).

Thomson (1995) explores continuities between the medical anti-abortion campaign and discourses that opposed female entry into education and employment in order to illuminate the large social context in which the anti-abortion efforts occurred. Women who sought education, beyond that knowledge which improved their duties as wife and mother, were thought to risk grave health implications including the loss of their breasts and their inability to produce healthy offspring. As with those who opposed abortion, the fear of degeneration of the race was central to the opposition to women's education. Medical justifications were also given to the opposition to women's

[9] These images of women aborting for selfish and frivolous reasons would maintain a powerful position in anti-abortion rhetoric throughout the next century, manifesting itself continuously in opposition to the idea of "abortion on demand."

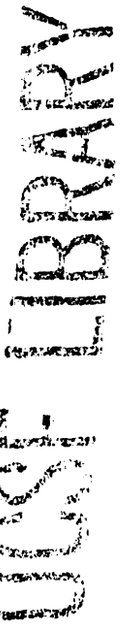
employment[10] arguing that it caused fetal disability and death, and increased the infant mortality rate.

Ironically although opposition to abortion was articulated in highly gendered terms, early feminists did not view abortion as a component of their struggle for women's rights. Although the dates of the anti-abortion movement coincide with those of the first feminist revolution, the early women's movement was not engaged in opposing anti-abortion efforts. Rather they sought to articulate disparate male-female relationships in alternative language and sexual imagery (Smith-Rosenberg, 1985). In what has been termed "domestic feminism," women sought power within the home through control of their husband's access to sex. They endorsed "voluntary motherhood," not through abortion but through abstinence and control (Stormer, 2002). The Female Reform Society, for example, in addressing the issue of women killed in abortion, concentrated not on the need to regulate abortion but rather to control seduction and prostitution. To these women, unregulated male sexuality, not abortion, threatened American society (Smith-Rosenberg, 1985). Others such as Elizabeth Blackwell, one of the earliest female voices within medicine, loudly denounced abortion (Hull & Hoffer, 2001). Her opposition to abortion is considered an early motivation for her medical career as she sought to reclaim the title of "woman doctor" from that of the abortionist (Stormer, 2002). However, while the public discourse among early feminists failed to articulate the need for abortion, the actions of many upper classes women who continued having abortions demonstrated an incongruity between formal positions of a community and the individual action of its members.

[10] In 1890 only 2.5% of white married women were in the labor force (Smith, 1973).

Criminal vs. Therapeutic Abortion

The first wave of abortion regulation in American history emerges from the struggles of both legislators and physicians to control medical practice rather than from public pressure to deal with abortion (Mohr, 1978). However, as the AMA leaders engaged in a campaign of propagandizing and lobbying among state medical societies, state legislatures, professional journals, and the popular press there was increasing support for the criminalization of abortion (Petchesky, 1990). Also as medical knowledge became a disciplining power, anti abortion ideology was used to maintain the power structure of the power, including medical, elites.



As a result of the AMA campaign, states began to pass anti abortion legislation in the second half of the nineteenth century, criminalizing abortions of all types and at any time in pregnancy. In 1873, Congress passed the first federal measure regulating abortion and birth control, the *Act for the Suppression of Trade in, and Circulation of Obscene Literature and Articles for Immoral Use* [17 Stat. 599]. Known as the "Comstock Law,"[11] it forbid the mailing of art, literature, and other materials deemed obscene (Smith-Rosenberg, 1985). Anthony Comstock, for whom the law was named, was not a member of Congress but rather the leader of the New York Society for the Suppression of Vice (Riddle, 1997). He was appointed a special agent of the U.S. Post Office empowered to enforce the new law through mail inspection (Tone, 1997), and given a fee for each arrest (Hull & Hoffer, 2001). A violation of the Act was punishable by up to five years imprisonment and a fine of up to $2,000 (Palmer, 2002). Between

[11] Most provisions of the Act dealing with contraception were repealed by Congress in 1971. The provision of the Act concerning abortion remains and was amended to prohibit distribution of abortion-related information over the internet. The act is unenforceable under *Roe v. Wade* (Palmer, 2002).

1873 and 1880 he arrested over fifty-five abortionists, more than any other inspector (Smith-Rosenberg, 1985). In 1878 he arrested Madame Restell Comstock (no relationship), the famous abortionist, who committed suicide the day before the trial (Riddle, 1997).[12]

The passage of the Comstock law would spawn the passage of new anti-abortion laws in dozens of states (Hull & Hoffer, 2001). By 1910 every state had outlawed induced abortion, except Kentucky whose courts judicially declared abortion to be illegal. Although abortion was criminalized in every state, most abortion laws allowed for "therapeutic" abortions performed when there was a threat to the life of the mother, or a serious threat to her health as determined by a physician (Mohr, 1978). The goal of the AMA campaign was, therefore, not to ban all abortions but rather the ultimately successful AMA position was that physicians should control the terms under which any "authorized" abortions took place (McFarlane & Meier, 2001). Changes in terminology reflect this shift. Prior to the AMA campaign the term "abortion" was synonymous with miscarriage, and "criminal abortion" referred to abortion after quickening; after the campaign criminal abortion referred to the any abortion not performed by a licensed physician (Stormer, 2002). Thus the physicians' success was in creating a distinction between criminal and therapeutic abortions (Keown, 1988) and in making access to legal abortion a physician's rather than a woman's right (Tone, 1997). As noted by Nossiff (1994), physicians had successfully framed abortion as a medical issue and established their role in determining when a woman's life was threatened by a pregnancy, thereby affirming medical knowledge as disciplining power.

[12] Ironically although she was a dispenser of herbal products she committed suicide by slicing her wrists rather than taking pills (Riddle, 1997).

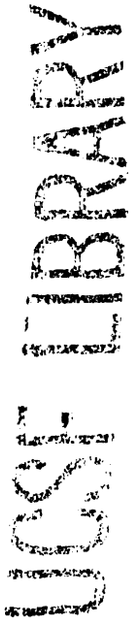
Criminal Abortion

Making abortion illegal did not make abortion go away. By 1930, the best available demographic estimates were that at least eight hundred thousand criminal abortions a year were taking place in America (Garrow, 1998). In 1957, Christopher Tieze of the National Committee on Maternal Health, who headed the statistical panel at a conference of experts on abortion called by Planned Parenthood, estimated that an estimated 1.2 million abortions[13] occurred annually in the United States (Lader, 1966). Many of these were criminal, some were therapeutic and many were initiated by the woman herself.

Those involved in performing criminal abortions were a very diverse group, who varied with respect both to their medical training, as well as their motivations. Some of those providers were trained; others were not. Some were highly competent; others caused hundreds of thousands of injuries and deaths. Some performed illegal abortions because of immense compassion for women in desperate situations; the motivation of others was greed. There were also licensed physicians who chose to offer illegal abortions as part of their regular medical practice. One example is Dr. Robert Spencer, a well-known abortion provider who practiced in Ashland Pennsylvania. He estimates that he performed about 75,000 abortions from 1923 to his death in 1969. During this forty-five year career he was arrested only three times and never convicted. Police were said to be reluctant go after him, convinced that abortion was a victimless crime that was best left alone (Gordon, 2002).

[13] The number of abortions in the United States has remained relatively stable. In 2000, 1.31 million abortions were legally performed (Finer & Henshaw, 2003); the number of illegal abortions is no longer estimated.

Many women, however, did not have access to a licensed physician and sought abortion services outside the health care system. Despite the high prevalence of criminal abortions, there were few indictments for performing these abortions and even fewer convictions (Tribe, 1992). Sheeran (1987) argues that despite their universal existence, anti-abortion laws did not have support beyond politicians and physicians, and as such they were rarely enforced. Some scholars hypothesize that the crime of abortion, like the crime of prostitution and gambling was protected during the years prior to WWII and that police either looked the other way or accepted bribes to protect abortion providers, similar to their protection of other illegal rackets (Hull & Hoffer, 2001). Reagan (1991) is one of the few scholars to actual study how states enforced criminal abortion laws. As with efforts to criminalize abortion, medicine played a unique role in the era of criminal abortion. Enforcement of these laws also continued to reflect the same process of maintaining race, class, and sexuality hegemonic power arrangements.



Selective Enforcement: 1900-1940

Reagan (1991) argues that up to 1940 the state prosecuted abortionists mainly after a woman had died, relying on declarations collected from women near death. In a dying declaration the woman was expected to name her abortionist, to tell when and where the abortion occurred, and the name of the man responsible for her condition. These declarations were usually collected from women before or during their medical treatment. After the woman died the policy would locate and arrest the abortion provider named by the dying women. S/he would be indicted and tried. The dying declaration would be introduced into the court room as testimony of the woman, an exception to the hearsay rule. Without these declarations there was no proof that an abortion occurred and

thus providers could not be brought to trial. Even with the declarations few providers were convicted of the crime of abortion.

Medicine played a complicated role in the enforcement of criminal abortion laws. Some physicians were active in assisting the state in its efforts to suppress abortion. Others, however, were unwilling participants in the state's efforts. Because the state could not investigate abortion cases without medical cooperation, state officials won doctors' help by threatening them. If physicians failed to report a criminal abortion they could be assumed to be involved somehow in the abortion and the investigation process could be turned against them. One way for physicians to protect themselves from legal trouble was to secure dying declarations from women whom they were treating. In 1902, the editors of the *Journal of the American Medical Association* endorsed a policy advising physicians to deny medical care to a woman until she made a statement ("Criminal Abortion"; as quoted in Reagan, 1991). However, while some frightened doctors denied medical care, others refused to act as a policemen for the state (Reagan, 1991). Many physicians resented the encroachment into their clinical care. In this way the rising power of the state as an enforcer challenged medical authority over the issue of abortion.

Regardless of the extent to which they collaborated with police, many physicians had relationships with criminal abortion providers. It was not uncommon for physicians to refer preferred patients to safe and reputable providers. This use of illegal providers should not be seen as endorsement or support. Lader (1966) referred to the relationship as "the Great American Hypocrisy" under which most medical professionals preferred to keep the skilled abortionist in practice but refused to take responsibility for them. One

example of this arrangement is the case of Dr. Loutrell Timanus, a highly skilled abortion provider with over twenty-five years of performing safe abortions (1 death in 5,210 cases).[14] Dr. Timanus was well known and routinely accepted referrals from physicians in mainstream practice. In 1950, he was arrested and charged with performing criminal abortions. Although he refused to reveal to the police the names of the physicians who referred to him, Timanus did send a letter to each of those physicians requesting that they appear in court on his behalf. No physician answered his letter and consequently he was convicted and sentenced to a $5,000 fine and six months in jail, later reduced to four and a half months.

According to Reagan (1991) enforcement of abortion law was used to discipline sexual behavior. Reflecting ideological constructs of gender and sexual normativity, the focus of most investigations was on working-class unmarried women.[15] While many married women had abortions, police records do not demonstrate that these abortions were the subject of criminal investigation. For unmarried women the penalties for having an abortion were imposed through humiliating interrogations about sexual matters by male officials at their deathbeds. One particularly important aspect of Reagan's work is its attention to how the state punished the unmarried working-class men whose lovers died. These men were often arrested, jailed, interrogated by the police and coroner, and sometimes prosecuted as an accessory to the crime. Men however who could prove that they had proposed marriage to the woman upon learning of her pregnancy received

[14] Dr. Timanus's safety record would later be included in a book advocating for abortion reform (Calderone, 1958).
[15] Although most abortions were for women who were married, prosecutors focused on unmarried women and the formulaic dying declaration assumed that the dying woman was unmarried (Reagan, 1991).

favorable status from the state. In this way both unmarried women and men were punished for their illicit sexual behavior.

Increasing Enforcement: 1940-1960

The enforcement of anti-abortion laws began to change in the 1940's. Where historically arrests came only after a woman died, new enforcement activities took the form of raids on abortion providers. The change in enforcement of abortion laws is typified in the story of Ruth Barnett,[16] a career abortionist in Portland, Oregon who practiced openly from 1918 to her first arrest in 1952. Dr. Barnett maintained an office in a downtown building and is said to have entertained politicians and newspaper men as well as "gamblers and whores." Barnett estimated that she performed over forty thousand abortions during her career (which ended in 1968) (Solinger, 1996). When Barnett was convicted for the first time in 1952, prosecutors attacked her for her lavish lifestyle, claiming that she had exploited desperate women. In reality, Barnett was said to charge no more than forty dollars for an abortion, far less than many other less competent providers (Hull & Hoffer, 2001). From 1952-1968 she was arrested and convicted three times. Barnett's story is also important to understanding the future of abortion provision where economic gain for performing abortions continues to be highly demonized and the source of much anti-abortionist rhetoric.

[16] Barnett was not a physician although she was trained by one. In her memoirs she claims to have never lost a patient (Solinger, 1996).

Therapeutic Abortion

Physician-Controlled

In contrast to criminal abortions, therapeutic abortions were performed by licensed physicians in their office or hospital for purposes of saving a woman's life. What constituted a threat to a woman's life, however, changed over time, and greatly reflected the circumstances of the era. Poverty was an acceptable reason during the depression of the 1930s. During the 1940s and 1950s doctors increasingly performed "therapeutic" abortions for psychiatric reasons, especially for women from upper income communities (McFarlane & Meier, 2001).

U.S. physicians performing therapeutic abortions in the mid twentieth century, however, faced an ambiguous, and increasingly, untenable situation. As childbirth became substantially less risky, "life-threatening" pregnancies became harder to justify, and in many instances, there was no uniform agreement on which conditions posed a true threat to the woman's life, or what degree of threat to her health merited an authorized abortion (Luker, 1984). The ambiguous legal nature of abortion created difficulties for physicians and had a chilling effect on the medical profession. Also as hospitals became more a site of care for the provision of abortions, physicians' activities became increasingly visible. Those who worked with women of reproductive age faced requests for abortions in a legal "gray area" where it was often not entirely clear what constituted a "legal" abortion and what did not.

Luker (1984) argues that the medical profession in the years leading up to *Roe* split into two wings with respect to abortion: the "strict constructionists," those morally opposed to abortion, who wanted their colleagues to adhere to the most rigid

interpretations of the laws governing authorized abortions, and the "broad constructionists," who pushed for a far more expansive and discretionary interpretation of abortion policies. In most American hospitals, abortion decisions were made informally, with inevitable tensions rising between the strict and the broad constructionists. This divide over the issue of therapeutic abortions undermined the physician solidarity with regard to abortion that had developed at the time of criminalization. As such it threatened the unchallenged expertise of physicians with regard to abortion, which had kept other professionals historically out of the abortion debate (Nossiff, 1994).

Therapeutic Abortions Committees

As an attempt to rationalize the abortion decision, and create professional uniformity with regard to abortion practice, physicians in the post-World War II years developed the "therapeutics abortion committee" system (Joffe, 1995). Prior to the formalization of these hospital review boards, the decision that an abortion was necessary to save the life of the woman was determined by the individual physician. Under this system, hospital abortion committees, typically composed of colleagues from several different specialties in a given hospital, would meet periodically to hear a physician present the case of his/her patient who was seeking an abortion. Of interest to note was that no laws required these boards (Corea, 1977) but rather they were attempts by the medical profession to establish standards for acceptable behavior. Such an effort can be understood within the theory of professionalization as discussed in the prior chapter.

The therapeutic abortion committee system, however, was unsuccessful in standardizing medical practice. A prominent study of that period by Packer & Gampell

(1959)[17] found considerable variations between Therapeutic Abortion Committees in different states and indeed within different regions in the same state as to which kinds of patient situations received authorization for abortions. In the case of one hospital, Mount Sinai, it was estimated that ninety percent of the abortions were technically illegal.

While not successful in creating professional solidarity, these committees were successful in reducing the overall number of therapeutic abortions. New hospital committees often imposed more stringent requirements on physicians. Many used quotas when determining the number of abortions they would approve in a given month. In this way hospitals acted as a brake on doctors' actions rather than allowing for expanded abortion decision-making (Hull & Hoffer, 2001). Individual physician autonomy was subjugated to the desire to create conformity across the profession. The major effect of these committees was to dramatically reduce the number of hospital-based abortions that took place in the United States; dropping from approximately 30,000 in 1940 to about 8,000 in 1965 and creating "one of the greatest cases of jitters to afflict the medical profession" (Lader, 1966:24). In one study, seventy percent of gynecologists surveyed in New York City and close suburbs answered that hospital abortions were more difficult to obtain than ten years earlier (as quoted in Lader, 1966). Women of color were disproportionately affected by these changes. Of the hospital abortions performed in New York City during 1960-1962 only seven percent were to non-whites (Lader, 1966).

As the numbers of in-hospital abortions declined the number of criminal abortions increased. Although there are no definite numbers, scholars acknowledge a rise in

[17] Herma Hill Kay would later testify before a US Senate committee (1981) that as a result of the influence of this article the reform effort in California would be led by doctors, lawyers and public health experts rather than members of the women's movement.

criminal abortions between the 1950s and the 1960s (Gordon, 2002). The 1950s was also a time of deep cultural shifts which led many women to seek criminal abortions outside mainstream medicine. The growing celebration of traditional family values and procreation caused many women who faced unintended pregnancies to seek secret criminal services to avoid the embarrassment and judgment of family, friends, and their regular reputable physician (Hull & Hoffer, 2001). In this way there was less support for the abortion decision than there had been 20 years earlier.

The Lack of a Countermovement

As discussed in Chapter 2 countermovements are a concept that contributes to the understanding of social movements. In the current abortion debate the strength of the oppositional movements, in many ways, defines the debate. Of interest during the period of criminalization reviewed is this section is the lack of an organized countermovement. Rather the women's movement of this time focused on the issue of birth control which like abortion was illegal at the turn of the century. As the growing birth control movement of the early twentieth century, led by Margaret Sanger, sought to legitimize itself, it separated itself from the issue of abortion, making a bright line distinction between birth control and abortion (Riddle, 1997). One of the central justifications for birth control became its capacity to reduce illegal abortion; thus abortion became a symbol of failure (Imber, 1990).[18] Abortion was articulated as not simply unsafe and crude, but also morally inferior to contraception (Imber, 1990). Although Sanger was said to personally support abortion, her public denouncements of abortion was the price she paid for the respectability of the birth control movement (Hull & Hoffer, 2001). The

[18] Imber (1990) argues that this symbol of failure is embedded in the word itself and one of the reasons that of euphemisms for abortion, i.e. pregnancy termination, have been such an important part of abortion debates.

legacy of this separation of abortion from birth control, which would later be articulated in law and in rhetoric as "abortion is not an acceptable method of family planning" would have powerful effects on the future of abortion in the U.S. and would be central to the continued marginalization of abortion from health care.

Summary

At the time of the formation of the United States abortion was a common and unregulated practice. Because childbirth, the alternative to abortion, was so dangerous for women, abortion was relatively safe by the standards of the time. The first efforts to control abortion occured in the mid 1800s and focused on a particularly risky type of abortion by poison. Further efforts to regulate abortion surfaced as part of a professionalizing project within medicine. During the mid 19th century the struggle between regular (or elite) physicians and other health care providers including midwives, homeopotheists, and apprentice trained physicians was resolved through the formalization of medical education and state-based licensing requirements. Able to control those who performed the work as well as what knowledge comprised the profession, medicine succeeded in attaining monopoly status. As a component of this professionalizing project medical knowledge became disciplinary power to produce and reproduce ideologies to maintain the privileged status of a hegemonic gendered elite structure. The social process by which the professionalizing project was successful is linked both historically and ideologically with the issue of abortion. In opposition to abortion regular physicians could distinguish themselves from other health care providers, especially midwives who were the major source of abortion care. In demonstrating the ability to enforce standards of behavior, the profession of medicine

was able separate their physicians from other unregulated practitioners. Because of its capacity to both control and distinguish the profession, abortion because a high priority for the newly formed AMA in the mid 1800s. In many ways the AMA can be thought of as the first abortion-related social movement organization in the U.S.

The medical practices of the day further developed anti-abortion knowledge as a form of disciplining power. By arguing that women could not know what they were doing it became the authority of medicine to both define and control the meaning of abortion. Where once "quickening," that is the capacity of a woman to feel fetal movement, was the standard for when abortion was acceptable, now the medical definition of life was the privileged knowledge. Textured within the anti-abortion ideology were gender/racial/ethnic conflicts. To the elite members of society abortion threatened traditional gender relations and represented potential race suicide as rates of abortions were higher for white, affluent, protestant women. Abortion was therefore seen as an indulgence of privileged women whose out of control behavior needed to be disciplined, in this case by both the elite society and the profession of medicine.

Abortion laws, while criminalizing most abortions, allowed for "therapeutic abortions" to save a woman's life. This distinction between what constituted a legal and an illegal abortion would perpetuate physicians as the arbitrator's of the meaning of abortion. However, abortions occurring outside medicine were viewed as criminal and thus their meaning belonged to the state. The state, however, needed physicians in order to enforce criminal abortion laws. In many instances the state utilized the power of coercion to engage physician involvement. In this way, physicians lost some of their authority over abortion. The state through its process of enforcement continued the anti-

abortion hegemony created in the nineteenth century using its power to maintain sexual and gender norms. Within medicine, the lack of uniformity in medical standards for what constituted a "therapeutic abortion" challenged the professional cohesion of medicine around the issue of abortion. In an effort to self regulate, hospital abortion committees were formed to police the actions of physicians and stabilize the profession. While these committees succeeded in limiting the number of therapeutic abortions they did not reduce, but rather increased, the number of criminal abortions. At the same time that the line between criminal and therapeutic abortion was being disciplined by the profession of medicine, the new birth control movement sought to separate birth control from abortion in an effort to gain legitimacy within medicine.

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CHAPTER 4: PHYSICIANS' ENGAGEMENT IN ABORTION LAW REFORM/REPEAL (1960-1973)

In the mid-century two things became clear about the medical practice of abortion: the method for abortion, dilatation and curettage (D&C) was relatively safe and the medical indications for abortion were decreasing (Imber, 1990). As such the medical profession was forced to address the controversy over abortion which disturbed its solidarity. Two avenues with respect to abortion were evident. The first, to allow increasing limits on the number of therapeutic abortions, contradicted the physicians' desire for control over the definition of abortion and the practice of medicine. The second strategy was to liberalize abortion law, either by reforming the existing laws or repealing them altogether. This chapter explores the progression of physicians' involvement with abortion liberalization initially through support for abortion reform and eventually repeal. Embedded in these discussions are concepts from the theories of professionalization, ideology/hegemony, and social movements.

Reform

For many doctors in practice in the years leading up to legalization, the laws created substantial medical confusion and there was tremendous uncertainty about under what circumstances "legal" abortions could take place. In 1966 the *Journal of the American Medical Association* published an editorial highlighting how more and more doctors were becoming aware of the discrepancies between the law and accepted medical practice (as quoted in Garrow, 1998). This widespread feeling of uncertainty led many in

the medical community to seek ways to bring abortion law into alignment with medical practice. Just as they had done in the effort to criminalize abortion, physicians of the modern era sought to align abortion with professional practices and thereby maintain the distinction between physicians who perform medically-defined abortions and those that performed criminal abortions. In many ways the abortion reform movement can be understood as a campaign for self-regulation by a producers industry (Mooney & Lee, 1995).

Early Voices for Abortion Reform

Between WWII and 1960 the profession of medicine,[1] with a few exceptions, paid little attention to the issue of abortion (Garrow, 1998). Much earlier, in 1933 two doctors each published small books advocating legal change. William Robinson (1933) in his *The Law Against Abortion*, issued by Eugenics Publishing Company, favored abortion legalization until the end of the third month and only for a certain number of times for any given woman. Abraham J. Rongy's *Abortion: Legal or Illegal?* (1933) called for the allowance of abortion justified by the health of a woman or other "valid" reason. Neither book was widely disseminated (Garrow, 1998). In 1936, Dr. Frederick Taussing's *Abortion-Spontaneous and Induced* (1936) briefly raised the visibility of abortion and his figure of 680,000 abortion per year was widely quoted in discussion about the abortion problem.

[1] During this period women's voices were largely absent from the professional public realm (Condit, 1990).

In 1942 Alan Guttmacher,[2] who had been named the chief of obstetrics at Baltimore's Sinai Hospital, spoke at the annual meeting of Birth Control (which would soon become Planned Parenthood) calling for liberalization of antiabortion laws to allow for legal therapeutic abortions whenever a woman's health might be at risk (Garrow, 1998). Also in 1942 a conference on abortion was held under the auspices of the National Committee on Mental Health; the proceedings of this conference were published in a 1944 book, *The Abortion Problem* (Taylor, 1944). However this book failed to draw widespread attention to the issue of abortion (Sarvis & Rodman, 1974).

A decade later, in 1955 the Arden Conference on abortion was sponsored by Planned Parenthood Federation of America (PPFA) and the New York Academy of Medicine. The proceedings, *Abortion in the United States* (1958), were edited by PPFA medical director Mary Calderone who organized the conference. One of the main conclusions of the conference was that abortion was no longer a dangerous procedure, and thus could be performed safely by trained physicians. Included in the proceedings was a description of 5,000 fatality-free abortions performed by the well-known illegal provider, Dr. Timanus, whose story drew the attention of *Time* magazine. Calderone's book spurred Alfred Kinsey to publish a study, "Pregnancy, Birth and Abortion" (Institute for Sex Research & Gebhard, 1958), which provided some of the first data on abortion in the United States. In the Institute of Sex Research sample of urban, white, educated women, one fifth of all pregnancies were terminated by abortion (Lader, 1966).

[2] Several experiences while in residency had influenced Dr. Guttmacher's position on abortion including the death of a mother of four children, the death of a 15 year old girl, and the death of a woman in middle age. All had received abortions at the hands of untrained abortionists. Soon after these experiences Dr. Guttmacher was prohibited from performing an abortion on a twelve-year old girl who had been impregnated by her father, solidifying his desire for abortion reform (Garrow, 1998).

In 1959 Guttmacher's twin brother Manfred took him to a meeting of the obscure, but influential, American Law Institute (ALI)[3] whose focus was drafting and promulgating a comprehensive set of statutes on abortion (Garrow, 1998). Three defenses against the charge of criminal abortion were articulated: 1) that the continuation of pregnancy would gravely impair the physical or mental health of the mother, 2) that the child was likely to be born with grave physician and mental defects, and 3) that the pregnancy was the result of rape or incest. The statute required that two physicians certify the circumstances that justified the abortion (Tribe, 1992). In 1962 these provisions became part of the Model Penal Code (Hull & Hoffer, 2001), which provided guidance to the states about how to craft their laws. Because of the prestige of the organization and the timeliness of their publication, the Code became the model for many proposed and passed abortion bills at the state level (Sarvis & Rodman, 1974). The importance of the ALI code to physicians is explained by Nossiff (1994:35): "Overall, the ALI definition of abortion provided the medical profession with a rights framework that enhanced its control of abortion policy and protected physicians from prosecution by the State."

In 1962, Morris Ernst, who previously had primary responsibility for PPFA legal work, noted the growing consensus that the medical profession was the correct segment of society to determine the future of abortion: "The health of our nation in this area of abortion waits no more than some simple dignified and thoughtful leadership. Only men in the health discipline are fit to so lead our people" (Ernst, 1962; as quoted in Garrow, 1998:285). In 1963 one of the first groups created to push for reform, "The Committee

[3] The American Law Institute was founded in 1923 by a group of elite law professors, practitioners, and judges and had immense influence upon private law and significant impact on public law (Hull & Hoffer, 2001)

for a Humane Abortion Law," founded by Sylvia and Dan Bloom (and soon to change its name to the Association for Humane Abortion [AHA]), selected Dr. Bob Hall as its presiding officer on the grounds that "the future of the organization can best be served by a physician in the role of chairman" (as quoted in Garrow, 1998:297). In 1965, the group again changed its name to the Association for the Study of Abortion (ASA) to reflect its commitment to conducting research, circulating news and copies of professional periodicals, and to answering questions on abortion (Sarvis & Rodman, 1974).

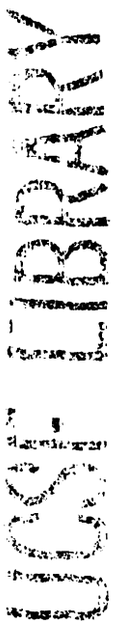
In midsummer of 1959, Guttmacher published a book-length statement of his views, advocating for liberalized reforms for general health, including socio-economic reasons and too many children (Guttmacher, 1959), although he continued to stress that he was opposed to abortion on demand (Garrow, 1998). In 1963 another conference on abortion was held in California. Consistent with the positions of the day, the focus was on expanding the circumstances for which a therapeutic abortion could be performed. Hull and Hoffer (2001:99) summarize: "The reformers were not trying to give women the right to an abortion outside the scope allowed by the doctors".

The distinction between acceptable abortion and other non-approved abortion as determined by doctors was articulated in numerous publications. For example, the *Christian Century*, a voice for liberal Protestantism, published a strongly-worded editorial calling existing abortion laws "barbaric and cruel" but stressing that "few doctors and few responsible people outside the medical profession would argue that all restraints should be lifted or that pregnancies should be interrupted because of some married mother's whim or some unmarried mother's shame or fear" ("Abortion Laws Should Be Revised", 1961:37; as quoted in Garrow, 1998:282). The language in this

limited support for abortion is reflective of the language used in the campaign to criminalize abortion. Women were still seen as inappropriate to make this decision as only physicians could determine when an abortion was necessary.

Recognizing the Medical Need for Abortion Reform

Two medical crises appeared in the 1960s that raised many more physicians' concern about the current status of abortion: The use of the drug thalidomide by pregnant women, and the exposure of pregnant women to German measles (rubella) (Hull & Hoffer, 2001). Thalidomide was developed by German chemists for headaches; it was never approved for use by the U.S. FDA but it was used by many American women as a tranquilizer. When used in early pregnancy thalidomide causes gross fetal deformities. Women exposed to German measles in early pregnancy were also at higher risk of genetic abnormalities. Two events brought these issues to the national dialogue: the Sherri Finkbine case and the case of the San Francisco Nine.

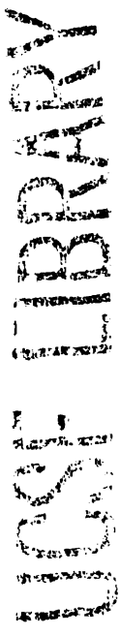


The Sherri Finkbine Case

Sherri Finkbine was the local host of the popular children's television program Romper Room. In 1962, when she was two months pregnant with her fifth child, she learned that she might bear a deformed child because she had taken a tranquilizer containing thalidomide. Although the Arizona law permitted abortion only to save the life of the woman, her doctor recommended an abortion. Hospital approval was given and arrangements made for the abortion. In an effort to warn others of the dangers of the drug, Mrs. Finkbine phoned a local newspaper and talked with the medical reporter, who agreed not to use her name in the article. However, the publicity caused the hospital to cancel her abortion out of fear that the doctor, hospital or Mrs. Finkbine could be

criminally prosecuted. The hospital unsuccessfully petitioned the State Supreme Court of Arizona for judicial clarity regarding the law.[4] At this point, the names of the Finkbines became a matter of public record, and they subsequently received thousands of letters filled with advice and hate. The couple eventually went to Sweden where the abortion was approved and performed (Sarvis & Rodman, 1974). Finkbine was in her thirteenth week of pregnancy and after the abortion the hospital told reporters that the fetus had been highly deformed (Garrow, 1998).

The very public ordeal and the extensive news coverage altered the national consciousness concerning abortion (Garrow, 1998).[5] Additionally it marked a fundamental change in the way journalism covered abortion moving away from only covering it within the context of crimes news and police raids against untrained and unlicensed abortionists (Garrow, 1998). The case became the first hospital-approved abortion ever subjected to national debate (Lader, 1966). As a result, a number of U.S. doctors queried their state medical association to clarify whether the threat of thalidomide-induced birth defects was an acceptable ground for proceeding with an abortion (Garrow, 1998). In many cases they were informed that the only legal abortions were those that were necessary to save the life of the mother.



The San Francisco Nine

Between 1962-1965 an epidemic of German measles (rubella) hit the United States, and was acute in California. It is estimated that this epidemic produced some

[4] In describing the case, Lader (1966:15) faults the physicians rather than the hospital: "Actually, the main stumbling...came from the doctors themselves. No individual obstetrician wanted to incur the blast of publicity that might seriously damage his career if he performed the abortion."

[5] Sherri Finkbine would later tell her story in a book edited by Alan Guttmacher in 1967, in which she hoped "that [her] case serves as a catalyst of sorts for abortion reform in this country" (Finkbine, 1967:25).

fifteen thousand infants with birth defects (Tribe, 1992). In several California hospitals doctors were performing abortions for these women in clear violation of the law which allowed for abortion only to save a woman's life. In these cases psychiatrists were asked to approve the abortion "under the rubric of a life-threatening 'mental health' crisis brought on by a woman's great psychological fear of giving birth to a severely deformed infant" (Garrow, 1998:301).

In 1966, nine San Francisco physicians were threatened with loss of their medical licenses by the State Board of Medical Examiners for performing therapeutic abortions on women exposed to rubella. The sudden decision to prosecute the San Francisco doctors was instigated by one individual, a strongly antiabortion member of the California Board of Medical Examiners (Joffe, 2003). The first charges were filed on May 21, 1966 against John Paul Shively, MD, Ob Chief, St. Luke's Hospital and Seymour P. Smith of St. Francis Memorial Hospital. Seven more charges were filed in June against Drs. Smith and Moss from the University of California, San Francisco (UCSF), Drs. Franzi, Chigos, and Parker from St. Luke's, and Drs. Spencer and Smith from St. Francis (Dynak, Weitz, Joffe, Stewart, & Arons, 2003).

This landmark event, known as the case of the "San Francisco Nine," took on lasting significance, however, because it led to an unprecedented mobilization among physicians, both in California and nationally, to defend their colleagues. Unlike the illegal abortion providers who did not receive support during their prosecutions, the professional stature of the accused physicians afforded them the support of their professional colleagues.

In response to the formal charges filed against the physicians, a Citizen's Defense Fund on Therapeutic Abortion was formed to raise legal defense funds for the San Francisco nine. Reflecting the professional status of the accused physicians, two elite individuals co-chaired the effort to support the accused: University of California Regent (the board of trustees for the University of California system) William K. Coblentz, JD, and UCSF Department of Pharmacology Chair Chauncey D. Leake, MD. In a letter describing the fund Coblentz and Leake wrote "At issue here is the basic right of all individuals to obtain the best treatment available to medical science and the right of physicians to offer that treatment without fear of reprisal (as reprinted in Dynak, Weitz, Joffe, Stewart, & Arons, 2003). Zad Leavy, JD, and Herma Hill Kay, JD (who would later become the Dean of the Boalt Hall School of Law at the University of California, Berkeley), authored a highly prestigious amicus curiae brief defending the doctors. This brief was signed by more than 200 physicians from across the nation, including 128 deans of medical schools and every medical school dean in the state of California (Leavy & et al., 1969). As reflected in the content of the brief, support was grounded in the rights of physicians rather than the right to abortion "The primary purpose of the anti-abortion laws [from the 19th century] is to protect the woman from unskilled abortionists and others operating outside the scope of sound medical practice" (Leavy & et al., 1969:39 as quoted in Garrow, 1998). Within four weeks of filing, the California Supreme Court issued a favorable order to Shively on procedural rather than constitutional issues (Garrow, 1998). As such no further prosecution occurred. However, it failed to resolve the larger issue about whether the abortions performed were technically legal.

The California Committee on Therapeutic Abortion (CCTA), which had been formed to advance abortion reform, gained momentum as a result of the increased publicity. The Committee was chaired by a prominent University of Southern California Medical School obstetrician, Keith Russell and financially supported by the wealthy contraceptive foam manufacturer Joseph Sunnen (Garrow, 1998). The goal of the Committee as explained by Elgin Orcutt, MD, Chief of Obstetrics and Gynecology at San Francisco General Hospital, who served as the local liaison for the Committee, was to provide "public education on the problems of abortion and family welfare, and about the archaic abortion statutes which prevents proper medical care of women..." (as reprinted in Dynak, Weitz, Joffe, Stewart, & Arons, 2003). In 1966 the California Medical Association formally endorsed therapeutic reform (Garrow, 1998).

As a result of the highly publicized nature of the case of the San Francisco Nine and the work of the CCTA, Anthony Beilenson (D) who had first proposed abortion law reform to the legislature in 1963, finally received the necessary legislative support for his 1967 Therapeutic Abortion Bill (SB 462) which was subsequently signed into law by Governor Ronald Reagan (R). The new CA law legalized abortion in cases of rape or incest, or to preserve a woman's mental or physical health. According to the law, legal abortions must be performed: within the first 20 weeks of pregnancy, in an accredited hospital of 25+ beds, and only after approval by a therapeutic abortion committee of doctors (Dynak, Weitz, Joffe, Stewart, & Arons, 2003). Legality was defined strictly in medical terms without recognition of any rights of women to control the decision.

Physicians' Involvement in Reform

Under the dramatic impact of the German measles and thalidomide problems as well as recognition of changing medical standards, many physicians began to advocate for liberalized abortion laws (Garrow, 1998). These concerns, together with ALI guidelines, merged into an abortion-reform discourse that supported expanded therapeutic abortion legalization. Abortion reform, thus, was framed as a desire to give expanded discretion to the medical profession (Stetson, 2001). The discourse articulated a growing concern about illegal abortion while presenting a solution to the newly recognized problem that was supported by both elites and the public (Nossiff, 1994).

Ironically, the medical profession which had lobbied to make abortion illegal became a principal advocate for changing abortion laws (McFarlane & Meier, 2001). In January 1965 papers devoted extensive attention to the results of a survey of New York state obstetricians' support for abortion reform. Eighty-seven percent of the twelve thousand obstetricians surveyed supported ALI-style therapeutic liberalization (Garrow, 1998). In March 1966, the Association of the Study of Abortion (ASA) sponsored a mail opinion survey of American psychiatrists that showed more than 90 percent support for reform but less than 25 percent backing for repeal. In one poll reported in the *Detroit Free Press* in 1967, the majority of 40,000 physicians surveyed were in favor of liberalizing the existing laws on therapeutic abortion (as quoted in Sarvis & Rodman, 1974:11).

In 1967, the AMA issued a statement favoring the liberalization of abortion laws.[6] The AMA, however, continued to reflect traditional views of women. To many AMA physicians abortion represented a threat to male authority and was a symbol of uncontrolled female sexuality (Joffe, 1995). Corea (1977) writes that physicians present at the AMA debate over the new statement argued that if a woman were allowed an abortion, she would not learn her lesson and would just become pregnant again. Pregnancy was seen as a woman's punishment for sexual behavior which was unacceptable to the physician. The disciplining power of medicine maintained sexual norms even as women were gaining increases access to abortion.

The "Tale of the Illegal Abortion"

For abortion reform to gain adequate support for the passage of reform legislation, the engagement of the public was also necessary. In order to breach the historical wall of silence about the issue of abortion a special discursive form was needed. Condit (1990) argues that the "tale of the illegal abortion" served as the perfect narrative for this purpose. In her study of abortion rhetoric[7] prior to legalization, Condit found that the media, rather than advocating for law change, recounted in graphic detail the tales of the abortion underworld. While statistics were used to relay the scale of the problem it was individual narratives that conveyed the nature of the human suffering and its moral status. Central to the story's persuasive structure was the good protagonist whose pregnancy was

[6] Prior to the AMA endorsement of ALI-style reform only seven state doctor groups had backed liberalilzation. In the three months following the AMA position announcement ten more followed the lead of the national body (Garrow, 1998).

[7] Condit argues that public discourse is constituted by "rhetoric." She acknowledges that the term "rhetoric" often carries negative connotations but that it is due to misuse by many social scientists outside the field of communication studies. For her rhetoric is "the use of language to persuade; the study of public discourse in its persuasive dimensions; that elements of a discourse which makes it appear truthful and therefore compelling; persuasive discourse; and the social process of governance through mutual persuasion" (Condit, 1990:228-229).

not her fault. The women in the stories were portrayed as innocent victims who were preyed upon by the evil abortionist (Condit, 1990). In this way the Finkbine story was ideal. Although her story does not include an illegal abortion, the lengths to which she went to avoid one, and thereby have a legal abortion, reinforced the notion of the evil illegal abortionist.

Media depictions of illegal abortions during this time also focused on the actual methods used to perform the abortion, often using "literally sickening" descriptions about the use of turkey quills, knitting needles, hairpins, and wire coat hangers (Condit, 1990:26).[8] The "back alley" became the common term for the illegal abortion scene. The tale of the illegal abortion "told the story of a good, ordinary person faced by social (not natural) circumstances that led her into evil scenes and self-destruction, magnified by gory details of the methods and scenes she was required to face" (Condit, 1990:27-28). These stories created what Condit calls a "mythic commonplace," which is based in important truths but are inevitably partial experiences told with emotional intensity. To create familiarity with the mythic commonplace, the tale of the illegal abortion was told repeatedly in the same manner.

In reality there was incredible diversity of the actual universe of abortion providers in the pre-*Roe* era. One report even estimated that ninety percent of all illegal abortions during this time were performed by physicians using sterile techniques (Condit, 1990). Regardless of his actual prevalence, it is the back alley "butcher" or "abortionist" (terms that have been used interchangeably) that is most commonly associated with this period (Joffe, 1995). The most egregious stories tell of men (some physicians, some not)

[8] The coat hanger would later come to have great symbolic meaning in the rhetoric of the Pro-choice movement.

who performed abortions in filthy settings, under the influence of alcohol, and who demanded sexual favors from their terrified and vulnerable patients (Lader, 1966; Messer & May, 1988; Miller, 1993).

The legacy of the "tale of the illegal abortion" had several lasting implications for abortion and medicine. The myth of the "abortionist" came to symbolize a potent combination of professional ineptness, ethical lapses and, of course, an association with the controversial issues of sexuality and gender (Jaffe, Lindheim, & Lee, 1981; Joffe, 1995). This aversion to the abortion provider—even while increasing support for legal abortion was growing within medical ranks—set the stage for the considerable challenges that would lie ahead for the medical wing of the abortion rights movement (Joffe, Weitz, & Stacey, 2004).

While the "tale of the illegal abortion" played an important rhetorical role, the realities that underlie it can not be ignored. Women who were seriously injured, either as a result of attempted self-abortion, or at the hands of an inept practitioner, so overwhelmed hospital facilities in the pre-*Roe* era, that some hospitals established special wards to care for them, sometimes referred to as "septic tanks" (a reference to the life-threatening sepsis infections in the bloodstream that often resulted from illegal abortion) (Joffe, Weitz, & Stacey, 2004). One respected estimate put the number of deaths from illegal abortions in the years leading up to *Roe* at 5,000 (Leavy & Kummer, 1962). Much of this damage was inflicted by women upon themselves using a wide range of herbs and instruments. In the 1950's Kinsey and colleagues estimated that seventy-five to eighty percent of septic abortions were self induced (as quoted in Solinger, 1996:x-xi).

The large numbers of women who sought care in emergency rooms for horrific

medical complications became a rally cry for physicians to advocate for further liberalization of abortion. As discussed in (Joffe, 1995) physicians practicing in the post-*Roe* era often recount their experiences with very sick women as justification for their current engagement with abortion care.

Reform Successes

In 1966, Mississippi passed a modified reform bill allowing for abortion in cases of rape and incest (Sarvis & Rodman, 1974). Between 1967 and 1972, most state legislatures considered changes in their abortion laws, predominately based on an ALI-style reform. In almost all states that witnessed 1967 reform efforts, backing came principally from local doctors (Garrow, 1998). It is important to note that while individual physicians were active in abortion reform efforts the AMA organizations were not involved (Lader, 1973). Of the ten ALI statues enacted between 1967 and 1969, state medical associations took active roles in only five (Halfmann, 2003 citing; Ingram, 1969; Jain & Gooch, 1972; Jain & Hughes, 1968; Jain & Sinding, 1972). The national AMA took no formal role in efforts to reform abortion law unlike its very active involvement in efforts to criminalize abortion. Its lack of engagement might be due to the reality that reform did not further its professionalizing project and that increased exposure to the issue threatened to reveal the lack of solidarity about abortion among the members of the profession.

Unfortunately, although popular opinion polls continued to support abortion reform, efforts to pass abortion reform laws met substantial opposition within the state legislative bodies. In 1967, reform advocates suffered early defeats in New York, Arizona, Georgia followed by defeats in Indiana, North Dakota, New Mexico, Nebraska,

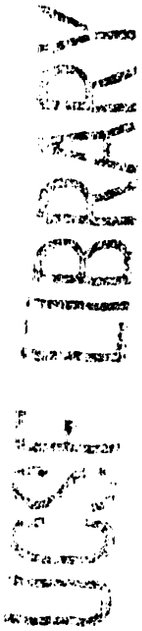
Texas and New Jersey. A surprising success was registered in Colorado which passed an ALI-style bill. Lack of organized opposition and an appeal to the law as a "health" matter are credited for the successful passage of the law. Bill sponsor Richard Lamm, a representative from Denver, explained his strategy "to use as proponents of the legislation the most conservative and responsible people we had at our disposal...ministers, doctors, and lawyers who had not previously been involved in controversial legislation of any kind" (interview with Garrow, as quoted in Garrow, 1998:324).[9] The bill that passed allowed for abortion for physical and mental health indications, fetal anomalies, and in cases of rape and incest. It also included both a parental and spousal consent requirements and a unanimous decision of each hospital's three doctor abortion committee (Garrow, 1998). It was a decision in favor of the professional authority of medicine.

Following the success in Colorado, an ALI-style bill was introduced and passed in North Carolina. Physicians took a central role in the hearings where three of the four supporting witnesses were doctors who have been recruited by the North Carolina Medical Society; the remaining witness was a Methodist pastor. All opposing witnesses had been arranged by the Roman Catholic church and included a science professor and two lawyers. One reason given for the apparent lack of success of the opposition is that only one percent of the state identified as Roman Catholic, the lowest figure in the entire U.S. The North Carolina law attracted less attention than the Colorado law because it included a residency requirement and did not expressly authorize abortions on mental

[9] Ironically the Colorado success was achieved without any formal involvement of the organized medical community. The short time frame between bill introduction and passage preclude the mobilization of formal support or opposition to the bill. The bill was introduced six weeks prior to passage (Garrow, 1998).

health grounds. It did, however, have a more fluid medical process mandating simply the approval of three doctors rather than unanimous consent of a standing hospital committee (Garrow, 1998).

The one anticipated success occurred in California which passed the Therapeutic Abortion Bill in 1967 (see discussion of bill contents above under "The San Francisco Nine"). Reform bills has been introduced as early as 1961 but not until the full mobilization of the elite community in response to the San Francisco Nine did momentum swing in favor of reform. According to Nossiff (1994), arguments in California used a medical discourse to build broad-based support for abortion reform. Additional, prochoice activists used the antagonism of the Catholic Church to argue that opposition to reform was religiously motivated, a charge which delegitimized antiabortion arguments for some members of the medical community (Nossiff, 1994). Medicine, not the church, was the appropriate arbitrator of issues of life and death.

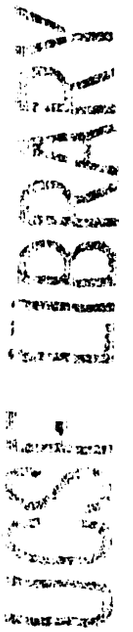


The Limitations of Reform

While the need for abortion by women meeting the ALI-style reform criteria garnered both medical and public support, few abortions actually met these criteria. Journalistic attention began to focus on the actual effect of abortion reform laws revealing how few additional legal abortions actually were being performed pursuant to the new reform laws (Garrow, 1998).

Abortion reform laws also failed to correct the problems of inconsistencies in the practices of hospital abortion committees. A California survey by CCTA president Keith Russell revealed that although eighty-eight percent of California's hospital abortions were done under the mental health justification, standards varied tremendously from one

part of the state to another (Russell & Jackson, 1969).[10] The California Department of Public Health (1970) reported that although the number of therapeutic abortions being performed in the state was nearly doubling every six months reaching 15,000 in 1969, legal abortions represented only about twelve percent of the total number of abortions performed that year. Physicians became increasingly disillusioned with both the process of needing to seek approval for their patients' abortions and the ongoing need to care for women suffering from poorly performed abortions who continued to fill the emergency rooms. Their changing perspective on reform was summed up by Edmund Overstreet, MD, Vice-Chair of the Department of Obstetrics and Gynecology at UCSF: "All in all, California's experience with the new therapeutic abortion law is not a happy one, and the law really satisfies no one." (Overstreet, 1970:141)



In November of 1968 virtually all of professional supporters of abortion law liberalization gathered in Hot Springs, VA for a highly unusual conference on abortion sponsored by the ASA.[11] The international conference followed an academic format with panels of speakers focusing upon different aspects of abortion (Garrow, 1998). At the conference the widespread dissatisfaction with abortion reform was raised by both physicians and lawyers. The nearly unanimous consensus of the meeting was that existing abortion laws needed to be abolished (NYT, 1968). Thus out of both a genuine sympathy for women seeking abortions and professional self-interest, more physicians began to fight to repeal abortion laws (Joffe, 1995).

[10] There was significant medical tension and disagreement over how the reform's mental health statute was being implemented (Garrow, 1998).

[11] At the conference participants were introduced to the vacuum aspiration technology that was both increasing the safety and decreasing the complexity of the abortion procedure (Dynak, Weitz, Joffe, Stewart, & Arons, 2003).

Repeal

The pressure for abortion repeal came from two groups, physicians and feminists (Gordon, 2002). Each of these groups received substantial support from the legal community but no organized legal movement was present in the struggles for repeal. Physicians and the women's movement, however, did not voice the original call for repeal. A few non-physician leaders led that charge. This section provides a brief summary of those lone voices and how they were joined by both the women's movement and the physicians. The legislative and judicial strategies for repeal are also explored, particularly the physicians involvement in those efforts.

Non-Physician Leadership[12]

In 1961 Patricia (Pat) Maginnis formed the Citizen's Committee for Humane Abortion Laws (Garrow, 1998), later reconstituted as the Society for Humane Abortion by Maginnis, Lana Phelan and Rowena Gerner. This group was the first to demand repeal of all abortion laws and openly provided information and education about abortion to US women. Reagan (2000) argues that most scholars of abortion underestimate the political significance of Maginnis' work.

After visiting abortion doctors in clinics in Mexico, Maginnis developed a referral list of the best ones and began standing on San Francisco street corners handing out the list to women (Lader, 1973). The goal was to connect women to safe abortion services and to incentivize providers in Mexico with more business if they met standards of safety in providing such care. In 1966 she created the California Association to Repeal

[12] Non-physician involvement in efforts to repeal abortion laws included many organizations and individuals. However as the focus of this chapter is on the role of physicians and the profession of medicine in the issue of abortion I have only provided a brief description of a few of the key non-physician actors in abortion repeal efforts.

Abortion Laws, directed at countering simple reform efforts with claims for repeal (Hull & Hoffer, 2001). She moved the discussion of abortion laws from professional meetings to the streets (Reagan, 2000). These efforts, however, received only minimal coverage in the mainstream press which continued to follow the reform efforts closely (Garrow, 1998) In 1966 the *New York Times* finally reported on Pat Maginnis's California self-instruction efforts, but the piece managed to call the thirty-eight year old Maginnis both "a zealot" and "a spinster" (as quoted in Garrow, 1998:308).

Other individuals such as UC Santa Barbara biologist Garrett Hardin argued that the right to abortion belonged solely to women and that abortion on demand was the only morally defensible position. His 1963-1965 speeches were often cited many years later when repeal efforts began to include women's rights as a component of its platform (Garrow, 1998). The call for abortion on demand however would fade in importance as the controversy over abortion increased in the years following *Roe*.

Another important voice in the early support for abortion liberalization was that of Lawrence Lader, a journalist from New York City. Lader was a founding member of ASA and was profoundly influenced by an early interaction with Pat Maginnis in 1966 (Lader, 1973). In his 1966 book *Abortion*,[13] he developed a strong case for broader abortion reform, advocating for the expansion of acceptable reasons for abortion to include social and economic conditions as well as those articulated in the ALI framework for reform. In graphic detail he explained the illegal abortion system comprised of sick, incompetent and often dangerous practitioners who were concentrated in depressed urban areas as well as powerful abortion rings that protect themselves from prosecution through

[13] Lader later served as chairman of the Board of National Association for the Repeal of Abortion Laws (NARAL) and as president of Abortion Rights Mobilization (ARM).

a series of illegal activities. In addition he highlighted the horrors related to the tragedy of self-abortion. Lader also linked opposition to abortion with the Puritanical obsession with sin that saw pregnancy as a punishment for immorality. He pointed to the ways in which abortion as regulated through therapeutic abortion committees abortion law interacted with race and class:

> "It is clear that such a system represents the most perverted form of morality. For that small group granted hospital abortions—an elite generally composed of private patients, educated, fairly wealthy and backed by influential doctors—it creates what amounts to a 'law for the rich.' Moreover, it produces open distain for the law among large segments of society." (Lader, 1966:8)

Lader would eventually become one of the loudest voices for abortion repeal, a story he recounts in his 1973 book *Abortion II: making the revolution.*

Perhaps one of the most visible groups supporting repeal was The Clergy Consultation Service on Problem Pregnancies (CCS) started in 1967 in New York City. CSS provided referrals to safe abortion services as well as worked to liberalize abortion laws (Sarvis & Rodman, 1974). Founded by a Manhattan pastor, Howard Mooney, with encouragement from Larry Lader, the newly formed organization announced publicly its support for repeal. The CCS was a network organized around a phone number and an answering machine located in Moody's Judson Baptist Church in New York City. Women who called would be referred to a designed clergyman for a private, face-to-face conversation, and only within this context would the woman be given specific information about an abortion provider (Garrow, 1998). Clergymen throughout the country participated in the CCS. Many referrals went to doctors in Puerto Rico but others went to Milan Vuitch in Washington as well as a doctor in Pennsylvania and a provider in New Orleans (Garrow, 1998). One goal of the open and aboveboard operating style of

the CCS was to convey the idea "that abortion on request could not be presumed to be an immoral or despicable act if substantial numbers of upstanding clergymen were serving as volunteer middlemen between needy women and legitimate doctors" (Garrow, 1998:334). As with prior efforts to promote reform, this argument reflects the ideology of medical control and power as legitimate. As a result of their highly public stance, mainstream reform supporters including Hall and the ASA initially publicly disassociated themselves from the efforts of CCS (Garrow, 1998).

Throughout the 1960s, the American Civil Liberties Union was also active in challenging state abortion laws (Sarvis & Rodman, 1974) although its chief proponent of repeal, Dorothy Kenyon, attracted little support from within the organization until its involvement in the challenge to Georgia's therapeutic abortion law (Garrow, 1998) that would be included in the *Roe* decision. It was not until 1967 that the ACLU adopted a resolution supporting abortion on demand (Hull & Hoffer, 2001). In late 1968 both PPFA and the American Public Health Association (APHA) publicly endorsed quasi-repeal resolutions (Garrow, 1998). The Task Force on Family Law and Policy to the Citizen's Advisory Council on the Status of Women (1968), a group established by John F. Kennedy, issued a report in favor of the repeal of state abortion laws, and called on state Commissions on the Status of Women to assume responsibility for educating the public on the need for repeal. In 1969, The National Association for the Repeal of Abortion Laws (NARAL) was established to provide a forum for those who wanted to engage in political action.

Perhaps the most important early repeal action was the publication, by a young law student named Roy Lucas, of a law review article applying the principals of *Griswold*

v. Connecticut [381 US 479 (1965)] to a woman's right to choose an abortion (Lucas, 1968).[14] Lucas insisted that a woman's right to decide not to remain pregnant was a fundamental constitutional right (Hull & Hoffer, 2001). In his article, Lucas laid out the grounds of a judicial challenge to anti-abortion laws because they were: 1) largely unenforced, 2) uncertain in scope, 3) at odds with accepted medical standards, 4) discriminatory in effect, and 5) subjective religious values imposed through criminal sanction (Lucas, 1968). Lucas' ideas would greatly influence the backers of repeal as well as the arguments in *Roe v. Wade*. Although predominately grounded in the rights of women, Lucas' argument continued to align the need for abortion with medical discursive practices.

Women's Movement

In many ways the women's movement came to the abortion debate late, after it had been dominated by men for thirty years (Hull & Hoffer, 2001).[15] As the new movement picked up the issue of abortion it would articulate very different justifications for abortion. Journalists such as Gloria Steinem and Claudia Dreifus would provide a public voice for full repeal mandates (Hull & Hoffer, 2001). These efforts would combine with the growing women's health movement in a vocal opposition to male control of the decision about and provision of abortion. This conflict would have consequences for access to abortion for many years (Joffe, Weitz, & Stacey, 2004), in

[14] Lucas developed an observation made by Thomas Emerson in a 1965 law review article on the legal aftermath of Griswold in which he observed that by using the Ninth Amendment as a basis for the decision, the Supreme Court had opened up an attack upon significant aspects of abortion law (Emerson, 1965).
[15] Unlike the agenda of the 19th century U.S. feminist movement (Gordon, 2002), women's health generally, and abortion rights in particular, were key concerns of the second wave feminist movement (Morgen, 2002; Petchesky, 1990; Rosen, 2000; Ruzek, 1978). For many of these groups, access to services was the primary focus and their lack of access to traditional power structures precluded them from being dominant forces in the push for abortion liberalization.

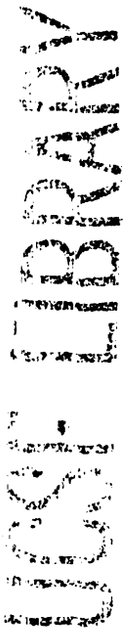
someway eroding the basis of mainstream support for abortion based in the legitimacy of medicine's right to control both its profession and the meaning of abortion. Gordon (2002) argues that the intense controversy over abortion after legalizations reflects the profound shift in the meaning of abortion, from a medical practice to a women's right, rather than opposition to abortion itself.

The National Organization of Women (NOW) did not openly address the issue of abortion until late 1967. At its second annual convention, NOW, pushed by author Betty Friedan, finally endorsed abortion legal repeal. This position profoundly alienated a significant number of members who did not believe that abortion had to be addressed by a women's organization. These women left NOW and went on to for the Women's Equity Action League (WEAL). Although it had adopted an abortion repeal position, NOW, as an organization, never took an active role in legislative efforts for abortion repeal; many of its members, however, were active in local-level repeal efforts (Garrow, 1998).

Formed in 1967, the Redstockings, another radical feminist women's liberation group did devote attention to the issue of abortion repeal. Perhaps best know for their disruption of the 1969 New York legislative hearings on an abortion reform bill,[16] the Redstockings were seen as outside the mainstream, and criticized for their activist efforts. One observer, writing of the period leading up to the New York law, spoke of pro-choice legislators' dismay at the "counterproductive 'strident' demonstrations and public testimony by militant feminists" (Moore, 1971:17).

[16] The Redstockings decided to disrupt the hearings because the witness list on abortion included fourteen men and only one woman, a Roman Catholic nun. At the end of the hearing three members of the Redstockings were allowed to address the committee (Garrow, 1998).

The Jane collective, established in Chicago in 1969, is perhaps the most famous of the feminist-related abortion activities of the pre-*Roe* period. The collective was a group of women, mostly in their twenties, who were connected to the leading local feminist group, Chicago Women's Liberation Union. The group initially operated an underground abortion service, making use of a provider whom they thought was a physician. The abortions took place in members' apartments and members of the collective assisted in the procedure. The name "Jane" was used in response to all phone calls, both as a security measure and as affirmation of the group's communal identity (Kaplan, 1995). Upon finding out that their provider was not a physician, some members of the collective asked to be taught so as to become providers themselves. The collective operated until 1973 when *Roe v. Wade* made their services no longer necessary. The group performed about eleven thousand abortions in all, with no fatalities, and only one serious confrontation with the police (Garrow, 1998; Kaplan, 1995; Reagan, 1997). The experience of the Jane Collective fundamentally challenged the notion that physicians were necessary to ensure the safe provision of abortion services.



By 1973, women's rights groups had taken a leadership role in developing national support for abortion repeal. The choices they would make in developing an abortion rights social movement had implications for the future of abortion provision and as such are discussed in further detail in a later chapter on the pro-choice movement.

Professional Medical Organizations

As the limitations of abortion reform were becomingly increasingly evident to physicians, there was growing support for the idea of repeal. In 1970 the AMA supported further reducing abortion restrictions (Garrow, 1998). The AMA resolution,

passed by its House of Delegates, was de facto abortion repeal. Although the resolution did contain a statement that doctors should not provide abortions "in mere acquiescence to the patient's demand" (American Medical Association House of Delegate, 1970:388), no limitations on abortion were given. The American College of Obstetricians and Gynecologists (ACOG) both led and lagged behind the AMA in their positions on abortion. In 1968 ACOG endorsed abortions for economic hardship if that hardship might affect health. However, it was not until 1972 that ACOG called for abortion on request, having only approved abortions to safeguard a woman's health or improve her family situation in 1971 (Lader, 1973).

During the debates regarding the AMA resolution, physicians articulated their concerns that abortion on request would eliminate any control physicians had over the abortion decision, thereby, rendering the former into a merely doing the patient's bidding (Joffe, 1995). As one physician noted, "Legal abortion makes the patient truly the physician: She makes the diagnosis and establishes the therapy" (as quoted in Jaffe, Lindheim, & Lee, 1981:67). The contradiction was understood even among those physicians leading the struggle for repeal as Robert Hall (Hall, 1970:109) explained, "When it comes to the doctor, I think he is eventually going to be no more than a technician. This may be humiliating to him. But it is his unavoidable plight if we are to grant women their inherent right to abortion."

Using what he calls a historical priorities approach, Halfmann (2003) seeks to explain the willingness of the AMA to allow the limitations on physicians' clinical autonomy which result when the patient, not the physician, makes the decision about the need for abortion. He argues that the AMA did not ascribe its highest priority to clinical

autonomy, but rather the AMA prioritized power over the economics and control of health care. At the time of the debate over abortion repeal, the practice of medicine was being threatened by discussions of socialized medicine, Medicare requirements, the establishment of new specialty organizations, and malpractice insurance.[17] As there was no mandate for physicians to perform abortions, the AMA did not see abortion repeal as a major limitation of physicians' control. The 1970 AMA resolution met the organization's priorities because while yielding some autonomy to women patients it increased doctors' autonomy from the state.

Although the AMA had a position statement supporting de facto repeal it refused abortion rights attorneys request to file an amicus brief in *Roe v Wade.*[18] Thus the professional organization of medicine did not play an active role in abortion legislative and judicial repeal efforts. Rather it was individual physicians who played critical roles.

Legislative Efforts to Repeal Abortion Laws

While legislative repeal efforts were mounted in many other states successes were reached only in Alaska, Hawaii, New York, and Washington. In 1970, Hawaii became the first state to repeal its criminal abortion law and to legalize abortion performed before the 20th week of pregnancy. The affirmative testimony of doctors weighed heavily in many legislators' decisions to support a repeal bill (Garrow, 1998). Although the first-in-the nation repeal bill drew widespread attention, the presence of a residency requirement limited its benefit to women outside the state (Garrow, 1998).

[17] In comparing the AMA and the British Medical Association's support for unregulated access, Halfmann (2003) articulates a major difference between the two systems that affects the way the organizations engage with the issue of abortion. The British physicians maintain a clientelist state-medical relationship while the private fee-for-service medicine in the United States creates a conflictual state-medical relationship.

[18] Although the AMA did not file support in *Roe v. Wade*, Justice Blackman was said to be influenced substantially by the 1970 AMA resolution (Garrow, 1998).

In what would become the most dramatic repeal fight[19] and the most important to American women, in 1970, New York passed an abortion repeal bill that allowed abortion to be performed up until the 24th week of gestation.[20] The 1970 bill, unlike its 1969 unsuccessful version, defined abortion as "treatment of a physical condition" that only licensed physicians could legally perform. While there was some opposition to the inclusion of the physician requirement by members of the radical wing of New Yorkers for Abortion Law repeal, the authors of the bill, Cook and Leichter, believed that failure to include such a requirement risked the opposition of a large segment of the New York medical community (Nossiff, 1994). The bill included no state residency requirement and no provision specified that the abortions needed to take place in a hospital (Garrow, 1998). The lack of a hospital requirement would facilitate the development of free standing abortion clinics and affect the future provision of abortion for the next thirty years. The formation of these clinics and they effect on abortion is discussed at length in the subsequent chapter.

The last highly visible repeal effort was undertaken in Michigan where a popular referendum was on the ballot in 1971. Initially predicted to pass by a large margin, a well-orchestrated campaign mounted a successful opposition to the bill. Thirty-second television ads purchased by "Voice of the Unborn" significantly shifted public sentiment. Prior to the airing of the ads fifty-six percentage of poll respondents said they favored the

[19] With the final floor vote separated by one vote, Auburn Assemblyman George Michael rose to his feet and said "I know I am terminating my political career, but I cannot in good conscience sit here and allow my vote to be the one that defeats this bill. I ask that my vote be changed from 'no' to 'yes'." (as quoted in Garrow, 1998:420)). With that the deciding vote was cast by the Speaker of the House and abortion repeal passed the New York Assembly (Garrow, 1998).

[20] In 1967 ASA, with backing from wealthy liberal philanthropist Stewart Mott, created an Ad Hoc committee for Abortion Law Reform to convey the impression that a popularly-based lobby group backed the New York abortion reform bill (Garrow, 1998).

referendum. On the night of the election only thirty-nine percent of voters supported repeal (Garrow, 1998). On that same election day a less covered measure in North Dakota also went down to defeat (Garrow, 1998).

Diffusion of Law Reform and Repeal

Before 1973, eighteen states would pass new abortion laws. Fourteen of those would be ALI-style abortion reform laws. Four states would repeal their restricitive abortion laws. Of the eighteen laws, one state reformed its law in 1966; three more states in 1967; two more in 1968; five in 1969; six in 1970 (including the four repeal laws); and one in 1972. These laws allowed abortion for different indications and included varying consent and residency requirements. For ease of reference information on these laws is in Table 1 below. Explaining this process of policy diffusion is informed by both overall theories of diffusion and one specific study of medicine's involvement in the diffusion process.

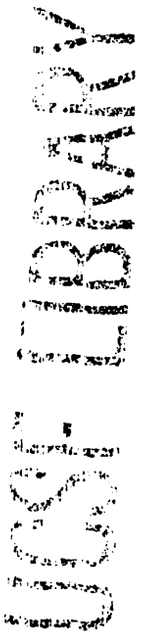


Table 1: State Abortion Laws prior to *Roe v. Wade*

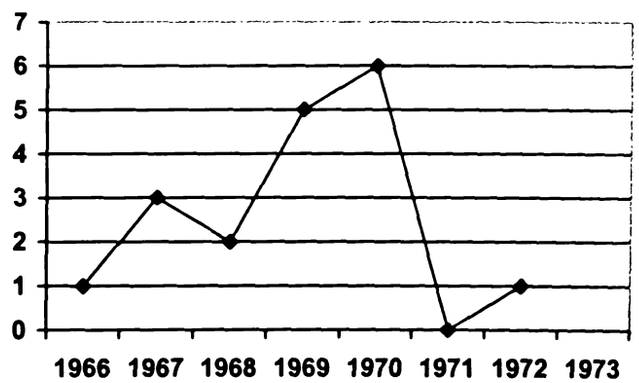
State			AK	AR	CA	CO	DE	FL	GA	HI	KS	MD	MS	NM	NY	NC	OR	SC	VA	WA
Date			70	69	67	67	69	72	68	70	69	68	66	69	70	67	69	70	70	70
Reform	Indications	Life		x	x	x	x	x	x		x	x	x	x		x	x	x	x	
		Health		x				x	x							x				
		Physical Health			x	x	x				x	x		x			x	x	x	
		Mental Health			x	x	x				x	x		x			x	x	x	
		Fetal deformity		x		x	x	x	x		x	x		x		x	x	x	x	
		Forcible Rape		x	x	x	x	x	x		x	x		x		x	x	x	x	
		Statutory Rape (yrs)			15	16			14		26		x	16			16			
		Incest		x	x	x	x	x			x		x	x		x	x	x	x	
	Requirments	Time Limit (wks)			20	16	20					26					150d			
		Residency		4mo			4mo		x							4mo	x	90d	120d	
		MD approval: Consultant		x			x	x	x		x					x	x	x		
		MD approval: TAB Comm.			x	x			x					x					x	
		MD approval: Hospital Rev.					x					x								
		MD approval: # MDs		3	2-3	3	1	1	2-3		3			2		3	1	3		
		Other Consent				x		x										x		
Repeal	Procedural Requirments	Physician	x							x					x					x
		Hospital	x							x										x
		Time Limit	nvf*							nvf*					24wk					4mo
		Residency	30d							90d										90d
		Other consent	x																	x

*nvf=non-viable fetus

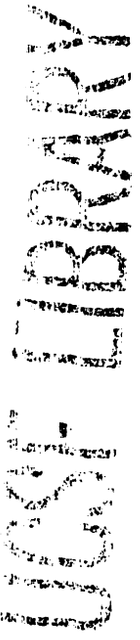
Source: (Sarvis & Rodman, 1974)

Theories of Diffusion: The literature on diffusion is expansive. In general the theories of diffusion stem from the work of Everett Rogers, whose 1962 book, Diffusion of Innovations is viewed as the birth of this theoretical tradition (Rogers, 1962). According to Rogers (2003), the rate of adoption for new innovations traditionally follows an S-shaped curve. The curve is created by the actions of five categories of adopters: 1) innovators, 2) early adopters, 3) early majority, 4) late majority, and 5) laggards. Several key components are focused upon when studying the diffusion process: innovativeness, opinion leadership, adoption rates for different innovations in a social system, and adoption rates in different social systems (Rogers, 2003). Initially studies of diffusion focused on products or technologies but as the field has matured new attention has been paid to the issues of diffusion of policies. Central to these studies is attention to environmental context variables (Wejnert, 2002). Figure 3 below graphs the number of states reforming or repealing abortion laws. The line does not appear to match the "S" curve predicted by theories of diffusion.

Figure 3: States Adopting Abortion Reform/Repeal Laws



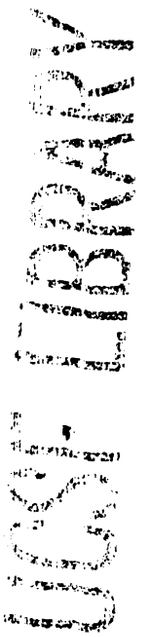
The Role of Physicians in Explaining Reform and Repeal Legislative Diffusion: A robust explanation for the pattern of abortion reform policy diffusion is provided by Mooney and Lee (1995) in which they found that abortion reform followed a social learning process that traditionally explains diffusion and reinvention in other types of policies and can be explained by three categories of factors: demand for the policy, the resources available to its proponents and opponents, and its constraints. However, unlike most economically-based policies, abortion reform must be understood as a morality-based policy and thus the specific demand, resources, and constraints are distinctly different. A morality-based policy raises questions over first order principles and thus results in uncompromising clashes of values. Because morality-based policies are more widely salient and lower in technical complexity than economically-based issues, a wider range of people have an opinion on the matter, thus public opinion may play a greater role for policy makers.



Of the factors used by Mooney and Lee to help explain early abortion policy diffusion, the contribution of the medical profession is particularly relevant to this paper. Mooney and Lee hypothesize that since abortion reform was a self-regulatory policy, the strength of the medical establishment in a state was likely to increase demand for abortion reform. Using a measure of the number of physicians per 100,000 population, they conclude that medical establishment influence helps predict the passage of abortion law reform prior to 1969. However as the morality-based debate increased in public intensity the influence of the medical establishment waned.

Ruth Bader Ginsburg (Ginsburg, 1985) would later argue that the *Roe* decision abruptly halted a process by which all states would have eventually legalized abortion.

Nossiff (1994) argues that such a perspective ignores the strength of the opposition to abortion. In 1972 Pennsylvania passed HB 800 which restricted abortion even further than its previous nineteenth century law. Although the law was vetoed by the governor, the support for the bill demonstrates that a succession to full state-level acceptance of abortion was not guaranteed. Mooney and Lee (1995) hypothesize that the conflictual nature of the abortion reform issue caused a truncation of the temporal learning curve and that many states may never have adopted these reforms if the Supreme Court had not intervened. In this way morality-based legislation may not follow the traditional S-shape of a typical learning curve. Weight is given to their argument by the slowing down of new policy adoption between 1971 and 1973 in which only one state, Florida, reformed its abortion laws.



Judicial Strategies

Between 1971 and 1973 no state repealed any criminal abortion laws (McFarlane & Meier, 2001). The strength of the growing right to life movement became evident in the fight over repeal in Michigan. During this period there was increasingly prominent usage of pictures of aborted fetuses, images that would be the mainstay of anti-abortion tactics subsequent to legalization (Garrow, 1998). As a result, further repeal efforts became almost impossible to imagine and proponents of repeal began favoring litigation rather than legislative change (Garrow, 1998). Like the legislative efforts, most of the initial judicial efforts privileged the role of the physician in the abortion issue.

Early Test Cases

Throughout the late 1960's and early 1970's those supporting legal solutions sought appropriate test cases. One case which received the support of many well

positioned individuals was that of Leon Belous, a well-known Beverly Hills gynecologist who had been found guilty of referring a patient to an abortion provider in Mexico (Garrow, 1998). The *Belous* case ("People v. Belous", 1968) received the financial support of Charles Munger, a wealthy Los Angeles attorney and his investment partners Warren and Susan Buffet. Arguing that "we need the establishment," Munger engaged one of the most prestigious California attorneys, former California bar association president, Burnham Enersen (Garrow, 1998). The three supportive amicus briefs reflected the support of the established members of society. One of these briefs, authored by Zad Leavy, was on behalf of a highly impressive nationwide roster of 178 medical school professors and deans, including University of Southern California Medical School Dean Roger Egeberg, who had previously declined the offer to serve as the chair of the newly formed CCTA (Leavy & et al., 1969). When the California Supreme Court issued its opinion on September 5, 1969, voiding the conviction on the grounds of vagueness, it relied heavily on Leavy's brief (Garrow, 1998).

In *Belous* supporters of judicial repeal efforts saw the first enumeration of certain basic rights of women over their own bodies. The *Belous* case was followed soon after by a U.S. District Judge's dismissal of criminal prosecution of the prominent abortion provider Milan Vuitch, also citing grounds that the anti-abortion statute was constitutionally vague. *United States v. Vuitch* (1971) would be the first abortion case to reach the U.S. Supreme Court. Without deciding on the constitutional questions, the Court sent the case back to the trial court for further proceedings requiring the prosecutors to prove that the abortion was not necessary to protect the woman's health (Rubin, 1998). Collectively these cases inspired hastened efforts to identify additional

tests cases in other parts of the country (Garrow, 1998). The aggregate impact of *Belous* and *Vuitch*[21] was visible in a widely publicized survey of over twenty-seven thousand doctors which revealed that a majority now backed repeal (as quoted in Garrow, 1998).

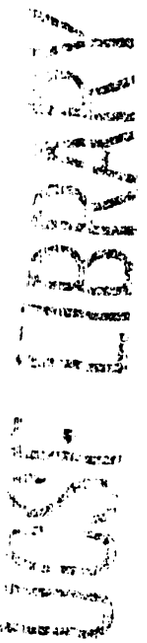
Another important case involving a physician was that of Jane Hodgson, MD, who had performed an abortion for rubella-exposure indications in Minnesota which did not have an ALI-reform law allowing abortions for fetal indications. Dr. Hodgson was officially indicted for the crime of abortion (Garrow, 1998). Recognizing the importance of her case as a test of abortion law, Dr. Hodgson waived her trial by jury to avoid sympathetic citizens who might acquit her. As expected the judge, after hearing testimony declared Dr. Hodgson guilty and sentenced her to thirty days in jail. Her case was immediately appealed to the Minnesota Supreme Court, lodging an official challenge to the state's anti-abortion law. Her case would eventually be resolved by the *Roe v. Wade* decision.

The most important of the judicial cases were *Roe v. Wade* filed in Texas in 1970 and *Doe v. Bolton* filed in Georgia in 1971 (which would be combined with the former in the *Roe v Wade* [410 U.S. 113 (1973)] decided by the Court on January 22, 1973). These cases would collectively come to be known as "Roe". Women's rights advocates often herald the *Roe* decision as the granting of "a woman's right to choose." As the below discussion illustrates, the *Roe* decision granted the right of abortion to women and their doctors. Some feminist critics of the decision argue that the right to abortion in *Roe* belonged predominantly to the physician (Copelon, 1990:302).

[21] Not all cases found in favor of the physicians: *Rosen v. Louisiana Board of Medical Examiners* ruled in favor of the states, finding that the state had the power to pass legislation protecting the fetus.

Medicine in *Roe v Wade*

In *Roe*, Norma McCorvey sued the state of Texas with the help of two new female lawyers, Sarah Weddington and Linda Coffee. The details of the path to the case have been made into several books (Faux, 1988; Garrow, 1998; Weddington, 1992) and even a television movie. Of importance to this discussion is that the case was fundamentally about medicine. Because the law did not criminalize a woman's attempt to abort herself or seek an abortion, McCorvey could not claim that the law punished her for trying to obtain an abortion. Rather the law prevented her from getting a safe abortion, by a reputable doctor, in a hospital (Hull & Hoffer, 2001). The second plaintiff in *Roe*, Marsha King sought the right to an abortion should she become pregnant. Recognizing the centrality of the role of physicians in the case, Weddington and Coffee included a third plaintiff, James Hallford, a physician who was to be prosecuted for performing abortions (Hull & Hoffer, 2001).



For Freidson (1970a), the preeminence of medicine is reflected in the authoritative and definitive status given to medical knowledge. According to Zola (1972), since abortion is viewed essentially a surgical procedure, it is to the physician-surgeon that society turns for criteria and guidelines. Accordingly, when writing the *Roe* decision, Harry Blackmun utilized the medical model to justify his interpretation of the law (Rubin, 1998). Such appeal to medicine reflects what Freidson (1970b:136) has called the "hierarchy of institutional expertise."

In the summer between the first and second oral arguments in the *Roe* case in front of the Supreme Court, Blackmun spent two months in the medical library at the Mayo clinic. He investigated the history of abortion statutes, the prior record of various

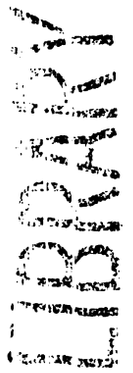
professional medical groups' attitudes towards abortion, and the status of abortion in the Hippocratic Oath (Garrow, 1998). His decision in *Roe* would reflect this prioritization of medicine as the basis for the Court's decision. For Blackman, abortion was essentially a medical decision, and the responsibility for it was upon the attending physician (Garrow, 1998).[22] Not until two-thirds of the way into *Roe* does Blackman address the constitutional rather than the medical questions. Although the AMA did not provide an amicus brief for the *Roe* argument, the AMA's position statement in favor of legal abortion was referenced in Blackman's decision. In the companion case *Doe*, the Court negated the need for the endorsement of the abortion decision by multiple physicians on the grounds that such a requirement unduly infringes on the physician's right to practice (Garrow, 1998).

Based on the medical trimester divisions for pregnancy, Blackman drafted the language that would become law, unregulated abortion in the first trimester, under proper medical conditions in the second, and at state's discretion after "viability" in the third. The decision states, "In the first trimester, the abortion decision and its performance must be left to the judgment of the pregnant woman and her physician". As Hull and Hoffer (2001:6) note, "Roe was a milestone in the relationship between (most often male) doctors and their female patients and thus becomes an important part of the history of the medical profession in America." The inclusion of "her physician" in the decision is not trivial and represents the success of a century of activity on the part of the medical

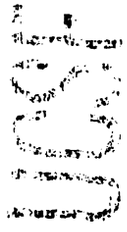
[22] As the years passed and more challenges to abortion were heard by the court, Blackman became an advocate for the woman's fundamental right to abortion. In the dissent in *Webster v. Reproductive Health Services* [492 U.S. 490 (1989)] he would write "The plurality would clear the way again for the State to conscript a woman's body and to force upon her a 'distressful life and future.'"

profession to define abortion as a medical problem. Through *Roe v. Wade*, abortion became a "legal medical procedure" (Lucas & Miller, 1981).

Blackman himself noted that medical advances could undermine the opinion by making fetuses viable earlier. Despite this, viability, defined through medical terms, became the standard for abortion. As Lucas and Miller (1981:80) explain, "most important, by not designating a specific time for viability, the Supreme Court left this determination to the physician's discretion." The woman's interpretation and meaning of her pregnancy was erased. In the *Roe* decision the ambiguity of when life begins is seen as the realm of medicine, philosophy and theology not of women: "[The Court] need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer" ("Roe v. Wade", 1973:Section IXB).



Roe further created "health" justifications for both the performance of abortion and limitations upon it. "Health" as a concept was defined in the companion Supreme Court case *Doe v. Bolton*. "There the court explained that a physician could make the health determination in light of many factors—physical, emotional, psychological, familial, and the woman's age...The Court also pointed out that this broad definition benefited the woman and provided the physician with the room he needs to make his best medical judgment" (Lucas & Miller, 1981:77). Issues such as equity and freedom and a woman's interpretation of her life circumstances became secondary to the medical definition and control over a pregnancy.



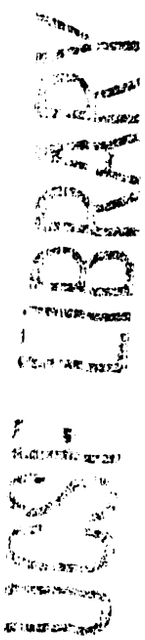
Several other unique aspects of the *Roe* and *Doe* decisions have implications for the future of abortion provision. In *Doe*, the Court struck down the hospital licensing requirements, and the requirement that two physicians certify a woman's need to undergo an abortion. As such it paved the way for the development of freestanding abortion clinics outside the hospital settings. Because of the importance of these clinics to the efforts of both the pro-life and the pro-choice social movements I review this issue in more detail in the subsequent chapter.

Another important component of the *Roe* decision was the allowance of states to prohibit the performance of abortion by non-physicians ("Roe v. Wade", 1973). At the time of the decision the implications of this aspect of the ruling were not evident. Since the time of the ruling, the role of nurse practitioners, certified nurse midwives and physician assistant has expanded within the health care delivery system. These non-physician health care providers have appropriate skills and training to be able to perform abortion services (Schirmer, 1997) and thus the potential for expanding the number of abortion providers (National Abortion Federation, 1991). However because of the decision in *Roe* most states still maintain a "physician-only" requirement for the performance of abortion.

While *Roe* and *Doe* answered several constitutional issues related to abortion, they left numerous unanswered questions that would be addressed in the subsequent decades. Left pending were issues of parental consent for minor's rights, reporting requirement, procedure type restrictions, institutional prohibitions, experimental use of fetuses, waiting periods, physician refusal to perform, and governmental funding restrictions (Lewis, Rosenberg, & Porter, 1981).

Summary

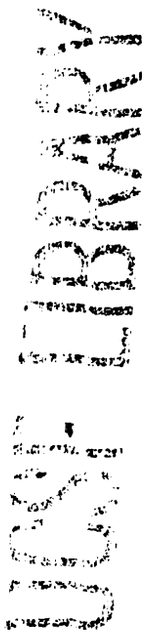
In the 19th century medicine used abortion as a means to professionalize itself. From WWII to 1960 little attention was paid to abortion and only a few medical publications addressed the subject. The medical crises over thalidomide and rubella brought public attention to the discordance between medical practice and the legal status of abortion. In reform efforts physicians sought to maintain dominance over the meaning of abortion, aligning the law with clinical practice. Of particular importance was the case of the "San Francisco Nine" physicians who were arrested for performing abortions for women concerned about the status of their fetuses exposed to rubella in early pregnancy. Widespread elite public support for these physicians demonstrates the extent to which abortion was seen as a medical matter rather than a morally problematic at this time. Initial reform efforts were based on the ALI model legislation that recommended allowing abortions when the pregnancy was the result of rape or incest, when it threatened the life or mental health of the mother, and when the fetus suffered from genetic abnormalities. Unfortunately while there was support for abortions under these conditions, few women actually needed abortions for these reasons. As such, these newly reformed laws did not resolve the abortion issue for either women or physicians.



Two rhetorical devices, the tale of the illegal abortion and the "mythic commonplace" of the back alley served to generate more widespread support for abortion reform and repeal. These discourses reinforced for the public the notion that nonphysicians were unsafe providers of abortion and that those who performed abortion were corrupt and inept. Both of these would influence how abortion would be provided after legalization and who would be allowed to perform abortions legally. The scene of

the back alley would be brought back to the public arena later by the pro-choice movement as threats to abortion rights surfaced in the 1980s.

As reform laws failed to meet the needs of the practice of medicine, the AMA endorsed repeal, although it continued to claim a lack of support for "abortion on demand." Other professional organizations also supported repeal including ACOG, APHA, and the ACLU. However, since repeal cut against the professional authority of medicine and the articulation of rights within the women's movement challenged the ideological control over abortion by medicine, the organized profession of medicine receded as a major player in abortion politics. Abortion repeal efforts were thus left to the legal and the women's community with the support of individual physicians who continued to play a role.



From 1967 to 1972 fourteen states passed abortion reform and four additional states repealed their abortion laws. One further restricted abortion although a governor's veto precluded the law from taking effect. Theories of diffusion do not seem to accurately predict the process of policy change which does not seem to match the "S"-shaped curve. One study of abortion law diffusion demonstrates the importance of the role of professional medicine in the process of reform/repeal adoption.

By 1970 the growing opposition to abortion legalization made legislative solutions increasingly untenable and thus judicial solutions were sought as an alternative strategy for abortion legalization. Initially the test cases of abortion law centered on the rights of physicians to practice medicine. However as a growing women's movement began to articulate abortion as a women's right, these claims began to be reflected in lower court decisions regarding abortion. The final test case, *Roe v Wade* would be

decided in 1973 and would legalize abortion in all states. The full answer to the question of whether abortion legalization would have occurred without Supreme Court involvement can not fully be answered. However, what is known is that in intervening in the abortion with its *Roe* decision, the Supreme Court profoundly changed the nature of the abortion debate from one about medicine to one about both medicine and women. During this process, however, it created law from medical knowledges about the meaning and purpose of abortion.

Roe also functioned as a catalyst rather than as the last word on abortion (Devins & Watson, 1995). Two large umbrella social movements developed in relationship to the *Roe* decision: those in support of legal abortion and those opposed to it. The titles used for these movements, "Pro-life" and "Pro-choice" are the ones most commonly used in mainstream discussions. The names, however, are highly contested by the opposition movement. Blanchard & Prewitt (1993) argue that the names given to and used by the movements should be seen as political statements, with each side resenting and protesting the names chosen by the other side as part of the work in which the movement is engaged. For the ease of the reader, this dissertation uses he most recognized names of the movements and discusses within the body some of the reasons for the name and the alternatives movement's opposition to that label. Each of these movements is taken up as a separate chapter in this paper. Before turning to this movement this dissertation explores the implications of the abortion care delivery system that developed as a result of legalization and that both facilitated and inhibited social movement actions to come.

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CHAPTER 5: ABORTION PROVISION AFTER *ROE*:

"THE ABORTION CLINIC" AND "THE ABORTIONIST"

As a result of a complex interaction of clinical care innovation, avoidance by mainstream medicine, engagement of the women's health movement, and the opportunism of entrepreneurial medicine, abortion provision would develop as a much more centralized rather than diffused delivery model. How about was offered who fundamentally affect the meaning of abortion. As Davis (1985:186) explains: "what abortion 'means' also became associated with the site or location of operation." To better understand how the site of care is important to an understanding of opposition and support for abortion, this chapter briefly reviews the concepts of medical geography as well as the actual trajectory of abortion care delivery after legalization. Recent work in medical geography offers some theoretical basis for an investigation into the importance of the space where the abortions are performed. The site of abortion care would come to be known as "the Abortion Clinic in everyday discourse a particular "place" imbued with social and embodied meaning. The Abortion Clinic was (re)produced from interaction between the freestanding clinics that emerged at the time of legalization and the simultaneous disengagement of hospitals and mainstream medicine from the provision of abortion.

Because *Roe* granted the abortion right to women only through physicians, understanding how physicians provide care becomes another critical point of inquiry in the post *Roe* era. As Tone (1997:xx) explains, "The legality of abortion will become a moot point if there are no longer any doctors willing to perform them." However,

performing abortions is not just another part of being a physician. Rather performing abortions became a form of specialization resulting from the failure of abortion to be integrated into mainstream healthcare and the entrepreneurial characteristics of those engaged in early services. These individuals are imbued with the legacy of the illegal abortion provider. Through a process of stigmatization and demonization being an "abortionist" has come to represent a negative social label that physicians seek to avoid. Theories of stigma help contribute to an understanding of this process and thus are reviewed in brief in this chapter.

The "Abortion Clinic" as Place

Theories of Medical Geography

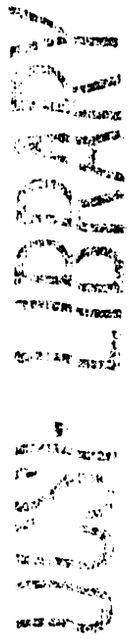
Historically medical geography has focused on either the geography of diseases or the geography of health care (Howe & Phillips, 1983) with most attention to the spatial distribution of disease (Catalano & Pickett, 2000). The geography (or spatial distribution) of disease embraces themes including the ecology and environmental associations of particular diseases. The geography of health care embraces the spatial properties of delivery systems and the accessibility, utilization and planning of health care services. For Kearns and Joseph (1993), a socio-spatial perspective of medical geography allows for a conceptualization of space which is both experienced by individuals and reproduced by social structures.

More recent theories of medical geography have raised the idea of "place" (Casey, 2003), with an attention to the difference between place and space (Gesler, 1991). Place is studied for its meaning to people and space is analyzed in terms of quantifiable attributes and patterns. Kearns, Barnett, and Newman (2003) argue that

place is primarily a social production. Thus while space is seen as an abstract concept, place is space transformed and given cultural meaning by human activity (Johnston et al., 2000). For Gesler (1991) it is in places that people become what they are. The distinction between space and place however, may be more ambiguous and fluid (Kearns & Joseph, 1993).

For Cartier (2003) these new theories of place combined with understandings about embodied subjectivity yields approaches for understanding the emplaced concepts of health service, arguing that the places of health care provision matter for those needing care as well as the health care professionals providing the care. Kearns, Barnett, and Newman (2003) focus on the text used to describe and depict a health care facility as a means of creating place. Stoller (2003) further explores the representation of space as meaningful in the production of place.

According to Casey (2003), the truth is a double truth realized through the praxis of place and the discursive, geographic, historical, and scientific practices of space. In seeking such an understanding the following discussion of the role of the freestanding abortion clinic in abortion provision is explored though this lens of medical geography.



The Development of Freestanding Clinics

The model for abortion provision was established in New York and Washington, D.C. where abortion was legalized several years before *Roe*. In New York the law legalizing abortion was passed in April 1970 and was supposed to take effect in July. Unlike the Hawaii law legalizing abortion, the New York law did not include a residency requirement. As such, abortion rights advocates anticipated that in July a nationwide flood of women seeking abortion would arrive in New York (Garrow, 1998). Given the

anticipated volume and the quick time frame between the law passage and implementation, abortion rights advocates were forced to make quick decisions about what sort of specialized clinical facilities could be established. The lack of any legal requirement that abortions needed to be performed in hospitals afforded advocates options.[1]

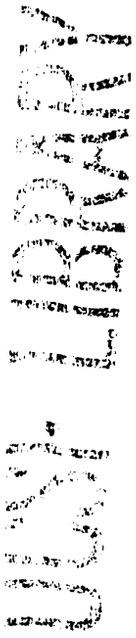
During the six weeks leading up to July 1st, intense debates occurred over how abortions should be provided. Concerns were raised that an unprepared New York City would be subjected to social and medical catastrophe (Pakter & Nelson, 1971). The New York City Health Department, joined by the New York Academy of Medicine and ASA president Bob Hall, suggested that on safety grounds abortions should take place only in hospitals. Other advocates including Alan Guttmacher and Bernie Nathanson supported the free standing clinic alternatives (Garrow, 1998). While many have depicted Hall's opposition as medically conservative, in retrospect his position was much more sophisticated than was appreciated at the time. Hall wrote that he wanted to force hospitals to perform abortions. And, as if able to read the future he forewarned: "If we let [hospitals] off the hook by setting up clinics, they'll never accept their responsibilities" (as quoted in Garrow, 1998:456).

In the end, in order to accommodate potential abortion demand, the early 1970s witnessed the development of the "freestanding clinic." In the first year after legalization in New York 18 freestanding clinics opened. The spatial separation of specialty services from hospitals to other locations is a trend that extends throughout medicine and is often

[1] In 1972, a court challenge to the hospital requirement in the Kansas reform bill would be negated by a three-judge panel in Kansas City. Data from the New York experience would be important to the court's decision (Garrow, 1998).

pushed by hospitals seeking to reduce expenses (Cartier, 2003). Thus while the separation is not unique, the early decisions about how to offer services would affect the future of abortion care in perpetuity.

Several technological advances of that period, including the introduction of the vacuum suction machine into U.S. medicine and reliable means of local anesthesia, which meant that abortions could be safely and comfortably delivered outside of a hospital, further facilitated the development of freestanding clinics. By offering the services in an outpatient setting with an attention to efficiency, the low cost of an abortion could be obtained. In addition, staff could be selectively hired because of their positive views on abortion, in contrast with using assigned hospital staff, including nurses that might hold negative attitudes about abortion (Dixon-Mueller & Dagg, 2002). As services were offered, the clinics amassed an excellent safety record (Grimes, 1992). Ironically, because free standing clinics were more likely than hospital-based services to use the new suction curettage technology instead of dilatation and curettage (D&C), these clinics reported fewer complications than hospital-based services (Pakter & Nelson, 1971). Thus it became increasingly difficult to argue for hospital-based delivery systems. An unintended consequence of the success of the freestanding clinics, however was the physical separated from mainstream health care.

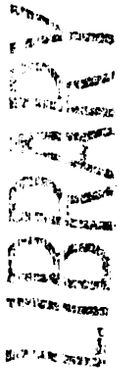


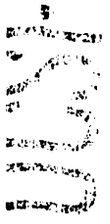
Regulation also facilitated the development of the freestanding health center. In October 1970 the Board of Health enacted the New York City Health Code (Article 42) requiring that non-hospital abortion services have a formal connection with and be within 10 minutes travel time of a hospital. In addition, other operating room capacities were required. These regulations eliminated private physician's offices as legal abortion

facilities while encouraging the development of freestanding specially equipped clinics (Pakter & Nelson, 1971). Many of these requirements would later be removed. New laws, called "Targeted Regulations of Abortion Providers" or TRAP laws would later be implemented in many other states requiring that abortion providers meet special physical and reporting requirements.

The women's health movement was also instrumental in promoting the development of the free-standing abortion clinics. Abortion was a key concern of the second wave feminist movement (Morgen, 2002; Petchesky, 1990; Rosen, 2000; Ruzek, 1978). As Starr (1982:381), commenting on the health care movements of the 1960s and 1970s observed, "Perhaps nowhere was the distrust of professional domination more apparent than in the women's movement." The feminist health movement sought a fundamental change in the physician-patient relationship (Woodward & Armstrong, 1979), challenging the power of medicine in general and the male obstetrician/gynecologist in particular (Ehrenreich & English, 1978). Women's health advocates resisted the total medicalization of various processes and states of women's bodies including abortion (Morgan, 1998). Reflecting this distrust of traditional care models for women, the women's health movement sought to create alternative systems for the provision of care to women. These feminist health centers often utilized abortion services as a central feature. Thus while many medical geographers argue that market pressures are central forces in the formation of delivery systems (see Cartier, 2003), the rise of the freestanding health center with regard to abortion demonstrates that social movements also play a role in the creation of delivery systems.

One of the first freestanding abortion clinics in the United States, the Center for Reproductive and Sexual Health (Women's Services), was founded by the Clergy Consultation Service (CCS) in 1970 immediately after the repeal of the New York abortion law. The CCS had several reasons for opening the clinic. First, they had a substantial track record for abortion referral. Second, CCS feared the economic exploitation of women. And third, based on their experience with abortion referrals, they were convinced of the importance of the non-medical aspects of the abortion experience. Women's Services is credited with pioneering the role of the abortion counselor who becomes the patient advocate giving clinic managers feedback on the abortion experience, including the sensitive issue of individual doctor's techniques (Joffe, 1995). Counselors in abortion clinics saw abortion in a very different light from mainstream physicians. Abortion was viewed as a positive step in women's lives, an opportunity for them to take control and make decisions, as well as an entry point into the larger women's movement (Eagan, 1994).





Freestanding clinics like CSS, set up and controlled by women, sought to help women with their health problems outside established institutions (Fee, 1977). Women were seen as the decision-makers about questions of their health. The physician's role was to provide information and services, not to determine the outcome of the decision (Eagan, 1994). This new model for the provision of care was difficult for many physicians. Joffe (1995:19) recounts the experience of abortion providers in the early part of the movement: "Making the adjustment to the [clinic] model--which was characterized by a 'team approach' and a decidedly nonhierarchical ethos--was admittedly

difficult for...many of the physicians who worked in the first generation of freestanding abortion clinics." Fee (1977:288) explains the dilemma for the clinics:

> Unfortunately, there was simply not enough women doctors to fill the demand. Many clinics have had to rely on male physicians to perform abortions while seeking to keep the control and policy-making power in the hands of women. There is real tension, however, between inherent power that comes from the possession of knowledge (in this case medical expertise) and the desire to keep power in non-expert hands.

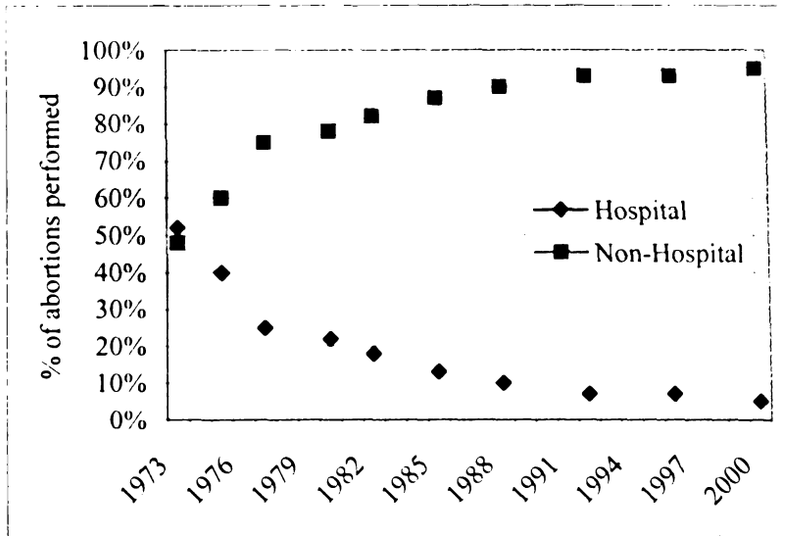
The model for feminist care where the patient was the central decision maker and her support came from non-physician personnel was also reinforced by the economic realities of trying to provide low-cost services.[2] Because doctors are the most expensive component of the provision of care, they are seen as expensive tools that should be used for that which only they can do, and everything else should be done by people who cost less (Joffe, 1995). Joffe (1995) argues that while this specialization carries with it a certain bureaucratic logic, it comes at the price of physician alienation. As one physician in Joffe's (1995) study explained, "I began to feel like the fool at the end of the curette," (:148) referring to the highly specialized role of technician which doctors have come to play in the clinics. Chavkin (1994:130) concurs: "[Abortions] relegation to sole-procedure clinics means that practitioners repeatedly perform a technically non-challenging procedure with limited gratification..."

[2] The notion that abortion care should not be profit generating has a long history in the dispute over abortion. Reflecting this tension was the experience of Roy Lucas, the lawyer who wrote the initial *Roe* arguments. In addition to his work on the early abortion legalization cases, Lucas also represented for-profit abortion referral services that challenged a New York law prohibiting their existence. Because of his support these for-profit entities he was not allowed to serve on the NARAL's board of directors (Garrow, 1998), as his support was seen as inconsistent with the mainstream pro-choice community's position against garnering profit from abortion care.

The Decline in Hospital-based Abortion Services

One of the striking features of the period immediately after *Roe* was the failure of the majority of hospitals to establish abortion services (Jaffe, Lindheim, & Lee, 1981). Academic obstetrics and gynecology departments did not actively recruit skilled abortionists to join their faculty. Joffe (1995) argues that the existence of the freestanding abortion clinics helped relieve many abortion-sympathetic physicians from the perceived burden of becoming an abortion provider themselves. Figure 4 below dramatically demonstrates the decline in hospital-based abortion from *Roe* to the present.

Figure 4: Decline in Hospital-based Abortions



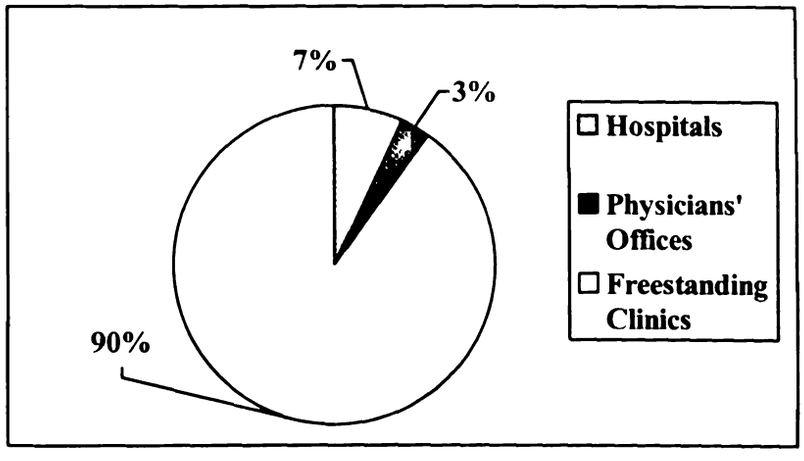
Sources: (Finer & Henshaw, 2003; S. Henshaw, Forrest, Sullivan, & Tietze, 1981; S. K. Henshaw, 1998; S. K. Henshaw, Forrest, Sullivan, & Tietze, 1982; S. K. Henshaw, Forrest, & Van Vort, 1987; S. K. Henshaw & Van Vort, 1990, 1994)

The shift of abortion to non-hospital settings received support from the courts. Since legalization abortion rights opponents have sought to mandate that abortions above a certain gestational limits, usually the second trimester, be performed in hospital settings. These bans have been consistently struck down by the court. In *Akron v. Akron*

Center for Reproductive Health Inc. [462 U.S. 446 (1983)] the Supreme Court found that the hospital requirement unnecessarily increased the cost of an abortion without significantly increasing a woman's safety (O'Connor, 1996). The 6-3 decision reflected the presence of the *Roe* Court. The three dissenters in this decision O'Connor, White, and Rehnquist did not agree with this conclusion.

Over the past four decades many medical procedures have moved from the hospital to outpatient care.[3] The transition of abortion care reflects this trend but is unique in its final manifestation. When most surgical services left the hospital setting, they were either incorporated into outpatient clinical care settings (i.e. the private doctor's office) or into multi-use surgical care centers thereby remaining part of a larger health care delivery system. Abortion, however, reflects neither of these models. Rather abortion services were provided through free-standing clinics. Figure 5 provides data on the percentage of abortions performed in these sites of care for the year 2000.

Figure 5: Site of Abortion Care, 2000

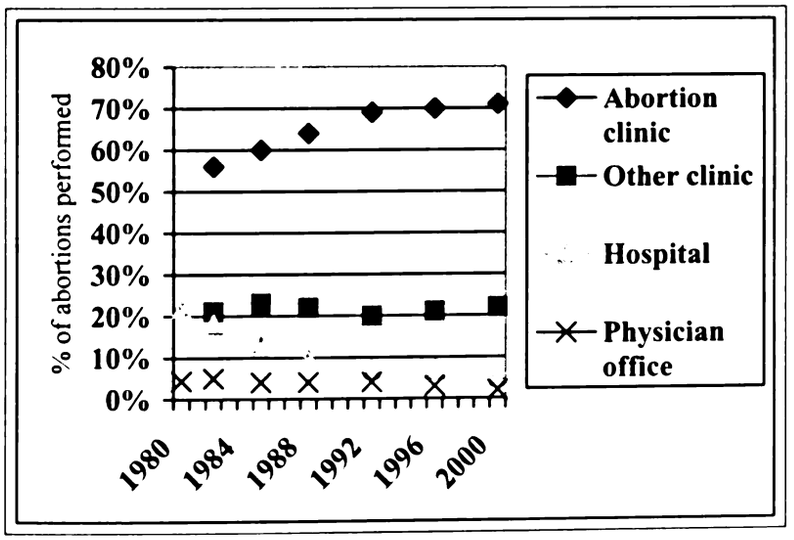


Source: (Finer & Henshaw, 2003)

[3] Westhoff (1994) argues that the record of the freestanding abortion clinic has not received appropriate credit as a major stimulus for the larger transition from inpatient to outpatient care that occurred in surgical procedures during the 1970s and 1980s.

Some of the free standing clinics offer more than just abortion care, for example Planned Parenthood clinics that also do family planning and routine gynecologic care. However, the majority of the abortions performed in the US occur within clinical settings where only abortions, or mostly abortions, are provided. Figure 6 shows the increasing percentage of abortions performed in free-standing were the majority of the services provided were abortion.

Figure 6: Provision of Abortion by "Abortion Clinic"



Source: (Finer & Henshaw, 2003)

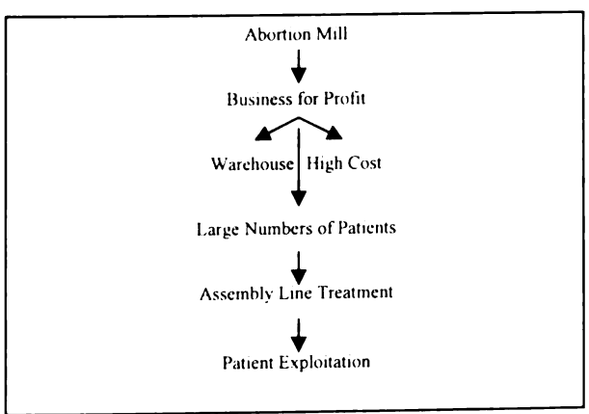
"Abortion Clinic" as Contentious Politics

Kearns et al (2003) posit that the language used to describe the institutions where care is provided create a particular kind of place, as this place and no other. As abortion care became centralized into clinical locations where only abortions, or mostly abortions, were performed, these sites became known as "abortion clinics." Thus abortion care became linked to a particular space where abortions were performed. The clinics became a place and the meaning of abortion would be linked for the general public with the

disruptions at these clinics that would develop in the 1980s. As will be discussed at length in Chapter 6: Pro-life Social Movement(s) (1973-present) these clinics because the site of engagement for abortion opposition as early as 1976. Blanchard (1994) contends that the clinics are ready targets for picketing, bombings, arsons and other forms of harassment because they are easy to locate and isolate. As a result abortion clinics were seen as a place of violence and social disruption and abortion was therefore understood as contentious politics. Abortion provision is therefore different from the rest of health care.

The consolidation of abortion care within a given clinical setting that performed high volume services also produced a "factory-like" image of service delivery. The pro-life opposition would come to refer to these clinics as "abortion mills." The public meaning of this label was laid out by Davis (1985) and is replicated in

Figure 7: Assumptions about the "Abortion Mill"



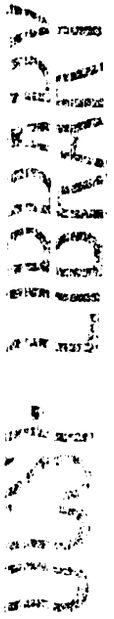
(reproduced from Davis, 1985:185)

The integration of this cultural understanding of the abortion clinic is taken up later in this dissertation in the article Weitz, T. A., & Hunter, A. (2003). Six Feet Under Brings Abortion to the Surface [Electronic Version]. *American Sexuality Magazine*, 1.

The Physician as "Abortionist"

In 2000, only 1,819 separate clinical locations admitted to performing abortion services and 86% of all US counties are without an abortion provider, representing a decline of 11 percent since 1996 and 37 percent since 1982 (Finer & Henshaw, 2003). In 1997, Kaiser Family Foundation reported that 57 percent of the ob/gyns who report ever having performed abortions are 50 years or older. At a poll taken at the plenary session of the 2002 National Abortion Federation conference, 50 percent of the approximately 200 attendees who stated that they performed abortions were over age 50 (Stewart, 2002).

Hypotheses to explain this "graying of the abortion provider" phenomena (Grimes, 1992) include the rise in anti-abortion harassment and violence, inadequate economic incentives for providing abortion, and the social stigma and professional isolation that accompany abortion work (Joffe, Anderson, & Steinauer, 1998). The issue of anti-abortion harassment and violence is taken up in greater detail in the subsequent chapter on the pro-life movement. The below discussion focusing on the professional isolation and stigma associated with abortion work. The isolation increased as mainstream medicine failed to engage with abortion provision and as increased specialization of the abortion provider further isolated him/her from the rest of the profession. The legacy of the "abortionist" and its stigmatizing potential are also explored.



Failure to Mainstream

In 1972, in anticipation of the imminent legalization of abortion, one hundred professors of obstetrics and gynecology (ob/gyn) published an open letter to their colleagues calling for an equitable sharing of the anticipated abortion patient load

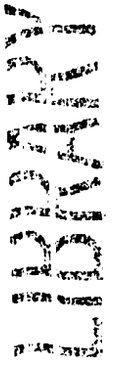
(AJOG, 1972). Accurately estimating that there would be about one million abortions requested in the first year after legalization, the statement confidently predicted, "If only half the 20,000 obstetricians in this country do abortions, they can do a million a year at a rate of two per physician per week" (AJOG, 1972:992). The events that would follow after legalization would not see medicine rise to this challenge of distribution of services. In sharp contrast to this statement, however, the period after *Roe* is noteworthy for what did not occur within medical institutions. Organized medicine reacted with a "surprising lack of enthusiasm" (Hodgson, 1998) and mainstream medicine's response to abortion has been called a "cop out" (Jaffe, Lindheim, & Lee, 1981:32). Today only two percent of the ob/gyns perform the majority of abortions in the U.S. (Hitt, 1998).

Physicians also quickly received legal protection for their unwillingness to perform abortions. Within weeks of *Roe*, the US Congress passed a law exempting federally-funded institutions, agencies, and individuals from having to participate in abortions or sterilizations. States followed suit and all but five states have adopted "conscience clauses" that exempt medical personnel and facilitates from participating in abortion care (Dixon-Mueller & Dagg, 2002). Such a position was supported by the AMA which while endorsing abortion legalization did not support abortion on request and retained as a matter of policy and practice the right of doctors to refuse to perform abortion (Halfmann, 2003).

The characteristics of the physicians involved in the early formation of these outpatient abortion clinics further exacerbated the marginalization of abortion care. In the only study of its kind, Goldstein (1984) analyzed the physicians who provided abortion directly after legalization in California in 1967. The physicians that shaped the

transition from hospital-based abortions to abortions controlled by clients and performed in freestanding clinics fit the definition of "entrepreneurs." These providers had greater support for women's rights and had positive views of profit-making, two features that separated them from traditional views of medical authority. As such, these physicians often lacked legitimacy within the professional community.

Professional reactions to this marginalization further separated abortion providers from other aspects of medicine. In 1977, National Abortion Federation (NAF) was formed as the major professional association of abortion providers in the U.S. and Canada (National Abortion Federation, 2003). Providers began to see themselves as members of this new professional organization and less a member of the other organizations, i.e. AMA and ACOG that had failed to embrace them as meaningful members of the profession.



Failure to Train

In addition to failing to provide abortion services, medicine failed to train new providers in abortion care and resident education bodies in the field did not initially mandate abortion training (Jaffe, Lindheim, & Lee, 1981). The low number of hospital-based abortions and the lack of trained abortion providers in those locations led to an immediate inability to conduct routine training in abortion procedures for ob/gyn residents (Joffe, 1995). A study conducted one year after legalization by Burkman, King, Burnett, and Atienza (1974) found that less than one-third of university programs provided educational experience for outside physicians and that most university departments had not made elective abortion an integral part of the service and educational responsibilities of obstetrics and gynecology. Three studies performed between 1976 and

1994 demonstrated substantial drop in the number of residency programs requiring abortion training. The results of these studies are summarized in Table 1 below.

Table 1: Abortion Training in US Obstetrics/Gynecology Programs

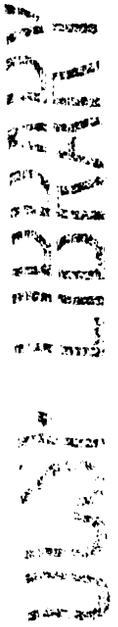
	Lindheim, 1978	Darney, 1987	McKay, 1994
Years covered	1976	1985	1991-1992
No. Programs	438	286	268
No. Respondents	213 (49%)	248 (87%)	233 (87%)
First Trimester abortion training			
Required	26.3%	22.6%	12.4%
Optional	66.2%	49.6%	57.9%
Not Offered	7.2%	27.8%	29.6%
Second Trimester abortion training			
Required	22.5%	20.6%	6.9%
Optional	61.5%	44.0%	58.4%
Not Offered	16.0%	35.5%	34.8%

(Reproduced from Westhoff, 1994:151)

In 1976, Lindheim and Cotterill (1978) surveyed the directors of all ob/gyn residency programs to determine whether training was required or available for ob/gyn residents. The conclusion of the study was that three years after *Roe*, only a minority of programs required residents to receive abortion training, although the vast majority of programs made it available to residents on an optional basis. The central question for the authors of this study was "why are some residents permitted to become Board-certified ob-gyns without having had any experience in performing abortions?" (:27). One answer to their question was that abortions were handled in freestanding abortion clinics and thus outside mainstream health care. The solution for Lindheim and Cotterill was to require hospitals to provide abortion services so that residents would receive adequate training within their regular environment.

The Darney study shed light on the increasing number of programs that no longer offered optional training and thus the increase in the number of training programs in which residents would not be trained in abortion care (Darney, Landy, MacPherson, & Sweet, 1987). Rather than see the free-standing clinic as the opposition, Darney et al saw it as a potential solution for the training crisis advocating for increased collaboration between the university hospitals and abortion clinics.

The MacKay and MacKay (1995) study found a sharp decline in the number of residency programs that required abortion training; now at less than 13 percent of programs. Also highlighted was the reality that only six percent of Catholic hospitals and no military programs offered abortion training. Hidden in the results of the study was the real meaning for the future of abortion care, the lack of adequate volume of procedures to train the physician to competence in the procedure: "In 45% of programs offering abortion training, residents performed one or fewer abortions per week" (:112). The paper looked to formal residency requirements regarding abortion training as a potential solution to the identified problem on inadequate training.



The crisis in abortion training among ob/gyn programs became increasingly apparent in the early 1990s. To redress the declining training in abortion care among ob/gyn residency programs, in January 1994, the Board of ACOG recommended that programs train physician and other licensed health care professionals to provide abortion services in collaborative settings (Westhoff, 1994). However requirements for clinical training for residents in ob/gyn are set by the Residency Review Committee for Obstetrics and Gynecology (RRC) of the Accreditation Council of Graduate Medical Education (ACGME). In 1995, after extensive consultation within the medical

profession, ACGME approved new standards for ob/gyn residencies requiring training in abortion and the management of abortion complications (Joffe, Anderson, & Steinauer, 1998). The strength of these requirements was severely mitigated, when in an unprecedented move, Congress stepped in and passed a law removing the enforcement of such training requirements (Hodgson, 1998)). The Coats Amendment[4] confirms accreditation by the federal government, and any state that receives federal funds, to any residency program even if it fails to comply with abortion training accreditation requirements. The result was that programs that failed to comply with abortion training requirements were not at risk of losing federal funds, the main enforcement mechanism for loss of accreditation (Foster, van Dis, & Steinauer, 2003). This congressional assault on abortion training was opposed by the medical community. As noted in a statement submitted on behalf of ACOG, "Congressional override of the ACGME requirements would represent an unprecedented involvement in the private education accreditation process...The implications of such an override are not insignificant" (as quoted in Joffe, Anderson, & Steinauer, 1998:326). Despite the opposition, no large-scale efforts were undertaken by mainstream medicine to resist the political intrusion into the profession. As such, abortion training standards have not been fully implemented and the providers of abortion remain marginalized from the protection and support of mainstream medicine.

A recent study of ob/gyn training programs by Almeling, Tews and Dudley (2000) sought to assess the status of abortion training after the formalization of standards for abortion training for ob/gyn residents. The survey found that 81 percent of programs offered abortion training, almost evenly split between elective and routine training. The

[4] The Coats Amendment was an amendment to the Omnibus Consolidation Rescissions and Appropriations Act of 1996 (Pub L. 104-134).

results of this study have been subject to substantial criticism (Landy & Steinauer, 2001). In particular several methodological errors are highlighted: the low response rate, the lack of a definition of routine vs. elective training, and the failure to ask for a description of the methods in which the residents were trained. Because the ACGME now requires that residents have access to training opportunities it is likely that the residency directors would report the availability of such training in order to demonstrate compliance (Landy & Steinauer, 2001). As such the appearance of increasing training opportunities for ob/gyn residents in the prior ten years should be cautiously interpreted.

Several other smaller initiatives have been undertaken to increase access to abortion training for ob/gyn residents. In 2002, California enacted AB2194 that reiterated the language of the ACGME requirements requiring that abortion be available in all six of the state-funded medical schools. In New York City, the Residency Training Initiative requires all ob/gyn residents in the City's eleven public hospitals to receive routine training in abortion (as with all abortion training requirements residents may chose to opt-out of performing abortions) (Foster, van Dis, & Steinauer, 2003). In 1999, the privately funded Ryan Residency Training Program was created to provide technical and financial support for residency programs to comply with the ACGME requirements. The program however has had modest gains: currently only 15 ob/gyn departments in six states have established formal rotations in abortion (Foster, van Dis, & Steinauer, 2003).

Another potential solution is the development of partnerships between hospital-based abortion residency programs and free-standing abortion clinics (Darney, Landy, MacPherson, & Sweet, 1987). Assessment of such programs have demonstrated success and high satisfaction among participating residents (Sankey, Lewis, O'Shea, & Paul,

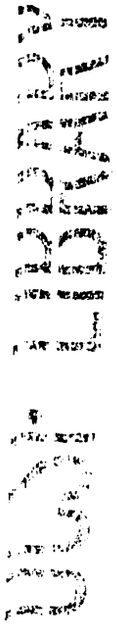
2003). However, one study showed that training outside the teaching hospital was negatively associated with second trimester abortion provision, perhaps due to the low volume of procedures performed in the external setting (Steinauer, Landy, Jackson, & Darney, 2003).

Abortion services, however, are not only provided by ob/gyns. Family practice physicians are also regular providers of abortion care. In 1992, training in the termination of pregnancy up to 10 weeks was recommended as a component of family practice residency training (American Academy of Family Physicians, 1992). Despite these requirements a 1993 nationwide survey revealed that only 12 percent of family practice programs offered abortion training (Talley & Bergus, 1996). A small local study in southern California found that even among programs that offered training, few residents had actually performed the service in the prior year (Lerner & Taylor, 1994). In 1995 (Steinauer, DePineres, Robert, Westfall, & Darney, 1997) conducted a national study of program director and chief residents of U.S. family practices residency programs. The inclusion of both residents and program directors helped illuminate the divergence between abortion training being available and people actually being trained in abortion care. According to (Steinauer, DePineres, Robert, Westfall, & Darney, 1997) although 29 percent of the programs included first-trimester abortion training as either optional or routine, only 15 percent of the chief residents had clinical experience in abortion.

The importance of training to the future of abortion is two-fold. Initially, physicians can not perform abortions if they do not know how to do them. But training also influences physicians' willingness to perform abortions. In a study of ob/gyns

practicing in the Bronx, NY, (Aiyer, Ruiz, Steinman, & Ho, 1999) found that positive attitude scores about abortion were correlated with physician experience with abortion; physicians who trained in residency programs in which watching abortions was compulsory has significantly higher attitude scores than those who did not.

Although small studies have demonstrated that training in abortion is related to the provision of abortion services (Shanahan, Metheny, Star, & Peipert, 1999), training alone is insufficient to create new abortion providers. As Steinauer et al. (1997) found, only five percent of the residents interviewed said they certainly would or probably would provide abortions as compared to 65 percent who stated that they certainly would not perform abortions, despite having access to training. The larger question of why physicians with positive attitudes towards abortion training and provision do not themselves do abortions after residency remains unanswered (Steinauer, DePineres, Robert, Westfall, & Darney, 1997). For example, while a only a few obstetrician gynecologist perform abortions, eighty percent of ob/gyn surveyed believe abortions should be performed under some circumstances, a number that has remained unchanged since 1971 (American College of Obstetricians and Gynecologists, 1985).

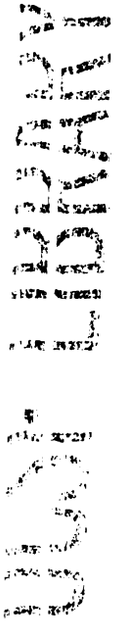


Legacy of the "Abortionist"

In an article in the New York Times, Kolata (1990) declared that physicians who perform abortion feel that they are stigmatized. According to Goffman (1963) the term "stigma" is used to refer to an attribute that is deeply discrediting. It is a "special kind of relationship between attribute and stereotype...[and] constitutes a special discrepancy between virtual and social identity," (:3-4) thereby reducing the individual to a tainted, discounted person. Goffman (1963) argues that "[w]e construct a stigma-theory, an

ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences..." (:5). He contends that we use specific stigma terms.

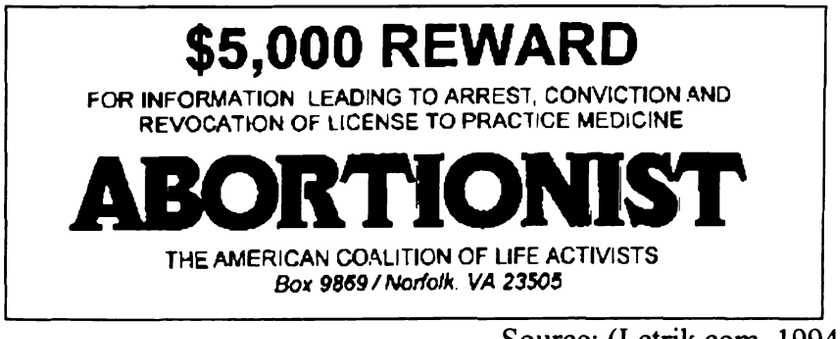
In the field of abortion the stigma-theory surrounding physicians who do abortions is coalesced in the term "abortionist," which has taken on specific meaning. During the time of illegal abortion, regular physicians, working in established medical facilities managed the complications of those women harmed in the provision of illegal abortion. These illegal providers, known as "abortionists" where viewed as quacks and public health enemies. They were seen as incompetent providers of care, extorting money from women in crisis situations. Even after Roe the term 'abortionist' continues to carry the unpleasant connotations of those who performed the service prior to legalization (Joffe, 1995). Joffe (1995) explains, that there is a lasting negative image of the illegal abortionist" characterized as a greedy, incompetent, and unethical "butcher." Blanchard (1994) posits that the anti-abortion movement has successfully characterized the abortion provider, both legal and illegal, as operating solely out of a profit motive and taking advantage women caught in moral and social dilemmas.



Today, being seen as an "abortionists" has extreme professional consequences and the stigmatization of abortion services is pervasive in contemporary medical practice (Joffe, Anderson, & Steinauer, 1998:322). One prominent abortion provider was denied access into a local country club simply because he performed abortion; the courts found that he had no grounds for a discrimination suit because unlike race, religion, gender which are seen as protected classes in the eyes of the law, occupations are not protected because they are seen as chosen (LifeSite Daily News, 2001). Subjects in Joffe's (1995)

study express failure to be promoted, exclusion from practice arrangements, and employment discrimination, as examples of the implications of providing services. As Joffe (1995:158) explains, "In many ways--some subtle and some not so subtle--those who provide abortions are often made to feel that they are outsiders in the medical community." Solinger (1998:4) concurs "The anecdotal, unsubstantiated taint attached to old-time practitioners has a way of bleeding across to infect the public and professional standing of contemporary practitioners, who with the myth intact, are 'justifiably' targeted by violent 'pro-lifers,' marginalized by the medical profession, and shunned by their own communities." Figure 8 below shows the use of the term "abortionist" in a flyer listing reward for what were termed the "deadly dozen," twelve of the most well-known abortion providers.

Figure 8: Deadly Dozen Award

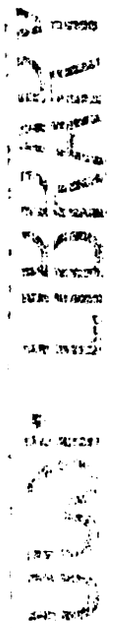


Source: (Letrik.com, 1994)

The case of Henry Foster, MD, is illustrative of the costs of stigmatization. Dr. Foster was being considered for Surgeon General under Clinton in 1995. The major point of opposition for the anti-choice groups was that Foster had performed abortions in his obstetrical practice (Shelton, 1995). During his testimony before the Senate Labor and Human Resources Committee, Dr. Foster admitted performing 38 abortions.

Although he no longer performed abortion, his past medical practice could not be removed. As a result of his prior association with being a "abortionist," Foster was forced to withdraw his nomination. The impact of this is explained by Goffman (1959:209) "The past life...of a given performer typically contain at least a few facts which, if introduced during the performance, would discredit or at least weaken the claims about self that the performer was attempting to project as part of the definition of the situation."

But the meaning of "abortionist" has moved from simply stigmatization to full demonization, which means to represent something/someone as as diabolically evil. According to Berlet and Lyons (2000), demonization often begins with marginalization, the ideological process in which target groups are placed outside the circle of mainstream society through political propaganda, creating a good-bad dualism. The next step is objectification or dehumanization, the process of negatively labeling a person or group of people as objects rather than real people. The final step is demonization happens when the person or group is framed as totally malevolent, sinful, and evil. Combined with demonization is the process of scapegoating whereby the hostility and grievances of a group are directed way from real causes onto a target group demonized as malevolent wrongdoers. Scapegoating often targets socially disempowered or marginalized groups while at the same time the scapegoat is portrayed as powerful and privileged (Berlet & Lyons, 2000).



The move from stigmatization is visible in the new label used for abortion providers "murderers and baby killers" (Blanchard, 1994). Such demonization justifies the call for the murdering of these providers in the name of a larger social good. How the

direct arm of the pro-life movement engaged in this process of demonization and how the discourses of "murder in the name of life" emerged is taken up in greater detail in the subsequent chapter on the Pro-life movement.

Summary

Theories of medical geography help to explain how the space where abortion provision took place after legalization would produce a new understanding of the abortion clinic as "place," imbued with social, cultural and political meaning. Legal allowance of the freestanding clinic and the advances in abortion technology combines were supported by the efforts of the early women's movement that sought to take the control over abortion provision away from the male physician. However, in creating a separate space where abortions were provided, abortion itself came to be understood as different from mainstream healthcare. As a result of these new clinics, hospitals provided a declining number of abortions so today only seven percent of all abortions are performed in a hospital setting. One impact of this decline is that abortion training is now increasingly less available to residents who are training in hospital settings. Another result of the physical separation of abortion services is that the "abortion clinic" became an easy identifiable target for pro-life direct action (discussed in more detail in the subsequent chapter). The disruption that would occur at these clinics would be linked for the public with the meaning of abortion itself as contentious politics. In addition the consolidation of services at these clinics further imbue these spaces with images of factories and bureaucraticization.

Just as the space where abortions occurred came to have social, cultural and political meaning so did the providers who performed those abortions. The failure of

mainstream medicine to take up the provision of abortion resulted in abortion care as a specialization within medicine. This specialization, however, would be both stigmatized through the label of "abortionist" and demonized as these providers were called "murderers." The failure to training new physicians in abortion care would further reduce the number of abortion providers and enhance their ongoing marginalization. Place and stigma would further negatively impact new providers' entrance into the field of abortion provision.

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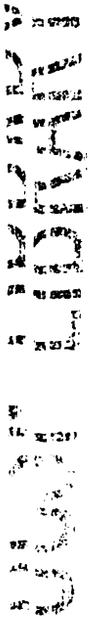

CHAPTER 6: PRO-LIFE SOCIAL MOVEMENT(S) (1973-PRESENT)

Within social movement literature, the pro-life movement can be understood as a countermovement (Lo, 1982) developing in response to success of the abortion law repeal movement culminating in *Roe v Wade*. Over the years, the Pro-life movement would engage in an iterative process of interacting with its oppositional movement the pro-choice movement, moving from mainstream political engagement to direct action. Key concepts of social movement theory are used to guide the discussion including the role of social movement organizations, the effect of political opportunities, the tactics chosen, and the meaning to activists. Also included are notions of identity, gender, and ideology.

Mainstream Political Engagement

Social Movement Organizations

Prior to *Roe v. Wade* most opposition to abortion law reform and repeal was led by the U.S. Catholic Conference[1] through its subordinate National Conference of Catholic Bishops (NCCB), its' Family Life Division, and its lay advisors. The Roman Catholic Church became actively engaged in anti-abortion activities as early as 1965 (Tatalovich & Daynes, 1981), when it adopted "The Pastoral Constitution on the Church in the Modern World," in which abortion was defined as a "unspeakable crime." As

[1] The Catholic Church was not active in the anti-abortion campaigns until the mid 1850s. In 1869, at the First Vatican Council meeting in Rome, Pope Pius IX dropped the reference to ensoulment (Riddle, 1997), declaring that there was no distinction between the animated and the unanimated fetus (referencing quickening) (Tribe, 1992). These proclamations have been interpreted to mean that life begins at conception. By the end of the nineteenth century the Church had determined that all abortions were a sin (Hull & Hoffer, 2001).

such, the first anti-abortion groups to form after the *Roe* decision were largely Catholic in composition and had the full elimination of legal abortion as its priority. At their Spring meeting in 1973, the NCCB recommended to the National Catholic Conference that it: organize right-to-life groups in every state, call on dioceses to fund church and ecumenical anti-abortion efforts, help the National Right to Life Association , and use one day each month for prayer and fasting in reparation for abortion (Faux, 1988). The National Right-to-Life Committee (NRLC) was formally organized from the U.S. Catholic Conference's group of lay advisors with extensive support from the NCCB (O'Connor, 1996) and was the first organization to assume a leadership position. Because of its organizational structure, movement participants were largely professionals who acted in opposition to the efforts of professional associations supporting abortion reform/repeal, i.e. physicians, lawyers, and social workers. Additionally, members of the NRLC were largely ecumenical and sought change through traditional means and appeals. The early efforts of the NRLC committee focused on the passage of a federal constitutional amendment prohibiting abortion. Conservative fundamentalist churches including the Church of Jesus Christ of Latter-Day Saints and Southern protestant sects also joined the early pro-life efforts. The first evangelical Christian anti-abortion group was not founded until 1975 when Reverend Billy Graham and future Surgeon General Dr. E. Everett Koop created the Christian Action Council. The Evangelical Christians, however, would prove to be the most powerful and political force in the newly formed pro-life movement.

O'Connor (1996) describes the early pro-life movement through the lens of political opportunities produced from changes in the tax code of 1974 which facilitated

the formation of political action committees (PACs) and thus the opportunity for the pro-life movement to engage in politics. Pro-life PACs were formed to target vulnerable pro-choice politicians using single-issue voting. For example, in 1977 the National Pro-Life PAC was established to elect members of Congress who would support a human life amendment (Blanchard & Prewitt, 1993). Fueled by these new PACs, the growing right to life movement would become closely aligned with the newly developing Christian Right.[2] Banding together for the 1980 elections, the Christian Right sought to tie anti-abortion, anti-feminist, anti-gun, and anti-pornography efforts into a single social movement. Central to early efforts were two social movement organization: the Moral Majority, a pro-life fundamentalist and evangelical ministry mobilized by the televangelist Reverend Jerry Falwell, and the Congressional Club, founded by Jesse Helms (R-NC) and direct-mail campaign finance guru Richard Vigurie (O'Connor, 1996). Abortion was part of a list of American sins that these organizations sought to stop.

Also in 1980, Judie and Paul Brown with the help of Paul Weyrich, a tactician for Ronald Reagan, founded the American Life League (ALL) to move closer to the New Right. The ALL spun-off from the NRLC with a more conservative but activist orientation. The ALL opposed birth control as well as abortion and supported direct action, two positions contrary to the NRLC more mainstream positions (Blanchard, 1994).

Paige (1983) uses a resource mobilization lens to explain the political and resource support received by the pro-life movement and its relationship to the New Right. The success of this merger resulted in the adoption of a Republican Party pro-life

[2] Berlet and Lyons (2000) argue that the defining feature of the Christian Right is the motivation by religious interpretations of cultural, social and economic issues.

platform calling for a constitutional amendment to outlaw abortion. This in turn was followed shortly by the 1980 election of Ronald Reagan, as a pro-life candidate. In additional to endorsing Ronald Reagan (who opposed all abortion except to save a woman's life) for president, the Christian Right targeted a hit list of congressional supporters of abortion rights. The newly formed Life Amendment PAC of the Moral Majority endorsed anti-choice candidates in key Senate and House Races. In 1980, abortion rights opponents secured the presidency with the election of Ronald Reagan.[3] Although they failed to win a majority in either the Senate or the House, the Christian Right became increasingly successful at using abortion as a litmus test for local and national candidates.

As disappointment grew over the Moral Majority's failure to secure a pro-life majority in Congress, a new social movement organization, the Christian Coalition replaced the Moral Majority as the leading political pro-life group. A refinement of tactics enhanced the success of the Christian Coalition. A strength of the Christian Coalition was the ability to mobilize concerned citizens to run for local office as well as to turn them into supporters and opponents of particular public policies at the local level. In this way it can be said that the Christian Coalition was geared toward conventional political action (O'Connor, 1996). The Christian Coalition also acted at the national level. Under the direction of Executive Director Ralph Reed, the Christian Coalition spent around $10 million to influence the outcome of the 1992 presidential election, distributing an unprecedented 40 million copies of its "Family Values Voter Guide" in more than 100,000 churches the weekend before the elections (Moriwaki, 1992; as

[3] Blanchard (1994) argues, however, that although the Moral Majority was given widespread media attention they had little effect on the 1980, 1984, and 1988 elections in which people voted for economic rather than moral issues.

quoted in O'Connor, 1996:146-147). Anti-abortion positions were a central factor of selecting and supporting political candidates.

Tactics

Historians have documented the tactics used by the pro-life movement to secure their agenda. Like the efforts to legalize abortion discussed earlier in this paper, several approaches could be used by the movement to secure the recriminalization of abortion, including legislative and executive political strategies as well as direct action. Throughout the decades following the *Roe* decision each of these avenues would be pursued, sometimes simultaneously and sometimes as a result of successes or failures of other efforts. The goal of the original efforts of the pro-life movement were to eliminate the legality of abortion which they saw as conferring legitimacy on abortion (Blanchard, 1994). Activities undertaken to eliminate abortion since the mid-1990s challenge this focus as they reflect an increasing concern with the practice of abortion in addition to the legal status of abortion.

Legislative Strategies

The anti-abortion movement which developed after the 1973 *Roe* decision had both a national and a state-based legislative strategy to seek the elimination of legal abortion.

National Efforts: The first legislative goal was the congressional passage of the Human Life Amendment. The initial efforts were led by the NCCB created National Conference for Human Life Amendment. By early 1976, more than fifty different kinds of constitutional amendments to ban or limit abortion had been introduced in Congress, all of which failed to get through both houses of Congress (O'Connor, 1996).

While unsuccessful at securing passage of the Human Life Amendment, the coalition led by the National Conference for Human Life Amendment were successful in accomplishing a second, more modest goal: to restrict federal payment of abortion for indigent women. In 1973, Senator Helms (R-NC) successfully amended the Foreign Assistance Act to ban the use of federal funds for abortion services and research. Also in 1976, the Hyde Amendment was passed prohibiting the use of federal Medicaid funds for abortion except to save a woman's life.

Efforts to pass national legislation regarding abortion continued from 1976-1994. In 1994 a record number of congressional votes (37) were taken on abortion issues and fourteen passed: criminalization of abortion speech on the internet, ban on abortions for overseas military women, ban on abortion in federal prisons, denial of abortion coverage for women in DC, bonus grants to states that reduced the number of abortion, limits on Title X family planning funds, and reversal of the requirement that Ob/Gyn residency programs teach about abortion. The most controversial was the passage of the Partial Birth Abortion Ban Act which was vetoed by President Clinton in 1996. The law would eventually be passed and signed into law by George W Bush in 2001. Immediate court challenges have produced temporary injunctions against implementation pending further review by the Supreme Court.

State Efforts: Immediately following the *Roe* decision abortion opponents began introducing anti-abortion bills in state legislatures. Within six months 188 bills had been introduced in 41 states.[4] The first post-*Roe* court decision regarding these laws came in 1976 in *Planned Parenthood of Central Missouri v. Danforth* [428 U.S. 52] in which, in a

[4] These early bills contained many of the regulations that would eventually be found constitutional in the *Planned Parenthood of Southern Pennsylvania v. Casey* [505 US 833] decision, including consent requirements.

7-2 decision the court rejected the right of a man to veto an abortion decision of his partner (O'Connor, 1996). Despite this set back, anti-abortion forces maintained an active legislative strategy seeking to restrict access to abortion at the state level. The first of these regulations to be upheld were state-based restrictions on the use of Medicaid funding[5] to pay for abortions for poor women upheld in 1977 in *Maher v. Roe* [732 U.S. 464], *Beal v. Doe* [432 U.S. 438], and *Poelker v. Doe* [432 U.S. 519]. The Court would eventually uphold the federal Hyde Amendment in 1980 in *Harris vs. McRae* [448 U.S. 297] in which, on behalf of Cora McRae and other poor women seeking abortions, a class action suit was brought against Secretary of Health and Human Services Patricia Harris under several provisions of the Constitution. In 1980 a divided Supreme Court found that the Hyde Amendment "rationally related to the legitimate governmental objective of protecting 'potential life.'" The government "may not place obstacles in the path of a woman's exercise of her freedom of choice," the court said "But it need not remove those not of its own creation, and indigence falls within the latter category."

Encouraged by the successes of securing funding restrictions, the pro-life movement sought to test the constitutionality of a wide range of restrictions that limited access to abortion rather than outright banning it. These regulations included consent laws, waiting periods, prohibitions against the use of public facilities, gag rules, etc. Until 1989 these restrictions were struck down at both the state and the district court level, based on the *Roe* decision.

In 1986 Missouri passed a law that dramatically restricted access to abortion services. The law, which declared that human life "begins at conception" banned the use

[5] States were allowed to continue to use their Medicaid funds to pay for abortion but they were under no obligation. Today only 17 states provided funding for abortion.

of public facilities for virtually all abortion and required physicians to perform medical tests on women who might be twenty weeks of more pregnant to determine if the fetus was viable. Several abortion services providers sued Missouri attorney general, William L. Webster, who later asked the Supreme Court to overrule *Roe*.

In 1989 the Supreme Court heard *Webster v. Reproductive Health Services* [109 U.S. 3040] challenging the constitutionality of the Missouri restrictions. When *Webster* was announced in July 1989, network news interrupted all regularly scheduled programming to announce the decision. Four justices (Rehnquist, Scalia, Kennedy and White) were willing to overturn *Roe* but they were unable to muster a fifth vote. Rather O'Connor wanted to uphold the Missouri statute as constitutional but under a new "undue burden" standard. The four justices in dissent, Blackman, Brennan, Marshall, and Stevens sought to uphold *Roe* but failed to have the votes. The Court fell short of overturning *Roe*, but a slim majority upheld every restriction of the law, on the grounds that "nothing in the Constitution requires states to enter or remain in the business of performing abortions" and that the medical-tests requirement of the law "permissibly furthers the States' interest in protecting potential human life." Although Roe survived its' framework was largely abandoned. Webster reflected the fractured nature of the Court with regard to abortion. For scholars of social movements *Webster* is a highly important case because of the record number of amicus briefs (78) were filed on both sides of the issue."

In 1989, as result of the success in *Webster* the National Right to Life Committee refocused its attention away from a human life amendment and toward a strategy of providing model legislation for states. This legislation called for a ban on abortion

except in case of rape incest, fetal abnormality, and when the pregnancy threatened a woman's life. The Catholic Church denounced these concessions and maintains an absolutist position on the non-acceptability of abortion. The NRLC de-emphasis on the total ban of abortion shocked and dismayed the more conservative far right-wing of the anti-abortion movement leading many to adopt a more aggressive and violent stance in order to stop abortion (O'Connor, 1996). A larger discussion of the growth in these tactics is discussed in a below section.

With the green light from the Court that some state based restrictions might be acceptable, the pro-life movement increased its efforts to pass state legislation. By July 1990 (one year after *Webster*) 350 abortion related bills had been introduced in state legislatures, two times the number filed in 1989 (Lacayo, 1990; as quoted in O'Connor, 1996:132). The pro-choice movement, in an effort to fight back against these new laws, continued to challenge their constitutionality in court.

In 1992 a challenge to the Pennsylvania law which included compulsory anti-abortion lectures by doctors, a twenty-four hour waiting period, a reporting requirement, spousal notification, and parental consent was heard by the Supreme Court in *Planned Parenthood of Southern Pennsylvania v. Casey* [505 US 833]. Nearly four months after oral arguments, a slim majority failed to overturn *Roe*. The majority stipulated that it would not permit states to enact any laws that unduly burdened access to abortion or to ban abortion altogether in the early stages of pregnancy. The plurality opinion (seven) rejected the idea that a woman's right to abortion was a fundamental right. Again four justices (Rehnquist, White, Scalia, and Thomas) said they wanted to overturn *Roe*. The majority opinion with O'Connor, Kennedy (who had sided with overturning *Roe* in

Webster) and Souter articulated the new "undue burden" standard. The remaining two justices (Blackman and Stevens) sought to keep *Roe* intact. In *Casey* none of the states impediments to abortion except one requiring spousal consent was deemed an undue burden (O'Connor, 1996). Thus while *Roe* remained intact, regulation of the right to abortion was now constitutionally acceptable.

Executive Strategies

Since *Roe*, each president has involved himself to some degree in the abortion issue (Blanchard, 1994). The role of the Executive in the success of the anti-abortion rights agenda is multifaceted involving both symbolic and material components. The election of Jimmy Carter in 1976 represented a success to the pro-life movement. Carter was a self-identified born-again Christian. His election gave a number of evangelicals their first taste of political organizing. In 1977 Carter signed the Hyde amendment cutting off Medicaid funds for abortions except in cases in which a woman's life was in danger (Blanchard, 1994).

While Carter gave the anti-abortion movement a minor success with Hyde, a real sense of empowerment can with the election of Ronald Reagan who, more than any other president, involved himself in the abortion issue through both active of symbolic and rhetorical support (Blanchard, 1994). Through control of the bureaucracy, Reagan effectuated policies to fulfill his campaign promises regarding abortion. He appointed a number of pro-life individuals to positions to prominent positions including Marjorie Mecklenburg, a founder of the National Right to Life Committee, as the head of the Title X national family planning program; and Dr. C. Everett Koop, as Surgeon General. Richard Schweiker, one of the original supporters of the Human Life Amendment, was

appointed as the Secretary of the Department of Health and Human Services. During Reagan's two terms he would issue a series of executive orders restricting abortion including a prohibition against abortions in the military, a ban on the use of fetal tissue in research, a gag rule against abortion counseling in federally-funded family planning clinics, a prohibition on research of RU486, a restriction on abortion-related activities for recipients of international family planning assistance. This use of executive orders to determine national social policy for which their was not Congressional support reflected a change in the overall power of the executive branch (Weitz, 1993).

The most bold charge about the extent of the anti-abortion agenda of the Reagan administration was made by Berstein (1992; as cited in Blanchard, 1994:75) who, based on several administrative sources, contends that Reagan struck a deal with Pope John Paul II with regard to abortion. According to Bernstein the Vatican funneled US funds to the Polish solidarity organizations in exchange for the administration's agreement to cut off birth control and abortion funding internationally. In 1984 Reagan cut off funds to the International Planned Parenthood Federation and the United Nations Fund for Population Activities (UNFPA).

George H.W. Bush's presidency largely maintained the Reagan policies (Blanchard, 1994). He implemented the Gag Rule and vetoed all four pro-choice bills that reached his desk in 1989 including the Congressional action to suspend the gag rule which had been imposed by executive order rather than through the legislature. Under Bush I, the Justice Department intervened on behalf of the Operation Rescue demonstrators in Wichita, Kansas, maintaining that clinic blockades constituted freedom

of speech under the Fifth Amendment (Blanchard, 1994) (see below for more discussion of the Wichita activities).

The ability of the executive to set social policy about abortion was tested legally in *Rust v. Sullivan* [500 US 173 (1991)], heard in October 1990 and decided in May 1991. In 1988 the Secretary of Health and Human Services had promulgated new regulation governing all federally funded medical facilities. The so-called "gag rule" prohibited physicians and other employees of such facilities from counseling pregnant women about abortion or engaging in activities that "encourage, promote, or advocate abortion as a method of family planning." Irving Rust, a doctor practicing in a New York City public hospital, sued Secretary Louis Sullivan on the grounds that the regulations violated the free-speech rights both of doctors and pregnant women under the First Amendment. Opponents of the regulations claimed that the law violated the first and fifth amendment rights of Title X recipients and the First Amendment rights of health care providers. Arguing on behalf of those opposed to the regulations was Laurence Tribe the renowned constitutional scholar from Harvard. Advocating on behalf of the government was a name that the U.S. public would come to know incredibly well during the Clinton years, Kenneth Starr. In a 5-4 vote, the Supreme Court in 1991 ruled that, since the government had not discriminated on the basis of a viewpoint, but had "merely chosen to fund one activity [childbirth] to the exclusion of the other [abortion]," the regulation did not violate the free-speech rights of doctors, their staff and their patients. The decision explained: "the employees freedom of expression is limited during the time they actually work for the project; but this limitation is a consequence of their decision to

accept employment in a project, the scope of which is permissibly restricted by the funding authority..."

From a political process perspective, the sixteen years of presidential support, both tacit and direct, for the anti-abortion position are seen as a source of the invigoration of the pro-life movement (Blanchard, 1994). Perhaps the most significant legacy of the anti-choice control over the executive are the Supreme Court appointments made by Reagan and Bush (Blanchard, 1994). Between Reagan and Bush, five Supreme Court appointments were made: Sandra Day O'Connor in 1981, Antonin Scalia in 1986, Anthony Kennedy in 1988, David Souter in 1990 and Clarence Thomas in 1991. These appointments led to the majority decision in both the *Webster* and the *Casey* decisions that changed the meaning and legal protection of the right to abortion.

In addition to a strategy to put justices on the Supreme Court that would allow for abortion restrictions and even consider abortion bans, the pro-life movement sought to pack the lower courts with anti-abortion sympathizers. Although the pro-choice community has raised concern about the judicial tactics of the pro-life movement no scholars of social movements have investigated this aspect of the movement.

Early Activists: Meaning

While political opportunity and resource mobilization social movement scholars tell the story of the organizations that comprised the pro-life movement and the tactics employed, other sociologists have continued to be interested in the people that actively joined the movements and in particular the meaning of abortion to those activists. The first major study in this arena was Luker's (1984) landmark work on activists in California. Luker found that differing views of motherhood, resulting predominantly

from class differences, explained women's engagement in abortion social movements. For those on the pro-life side, in particular, legal abortion was a referendum on the value of "stay-at-home" motherhood.

Also seeking to answer why individuals joined movements, Ginsburg (1989) studied the battle over the opening of an abortion clinic in Fargo, North Dakota. In contrast to Luker, Ginsburg did not find socio-economic differences, but rather generational ones. Like Luker, Ginsburg argues that those engaged in oppositional movements saw the meaning of abortion differently. Her work concludes that abortion is a symbolic focus for the assertion of mutually exclusive understandings about the place of women in society.

Scholars who disagree with Luker and Ginsburg's conclusion that gender is a central organizing principle for the pro-life movement provide alternative explanations of the reasons for participation in the pro-life movement. In his history of the pro-life movement Cassidy (1995) argues that reducing pro-life to issues of gender is simplistic and inadequate. He posits, in contrast, that the meaning of human life and the absolute character of fetal rights, grounded for many in religious convictions, are central for such activists. Not all women who joined the pro-life movement, however, identified with the narrow world view laid out by Luker and Ginsburg or the religious perspective articulated by Cassidy. A small, often marginalized sect of the pro-life movement identify as pro-life feminists. Their perspectives have been brought together in an edited volume by MacNair, Derr, and Naranjo-Huebl, (1995).

Outcomes

Assessment of the extent to which the pro-life movement has been successful depends a great deal on the political positioning of the scholar making the assessment. In a collection of essays by leading members of the Pro-life movement on the future of their movement, the authors highlight the extent to which the movement has failed, referencing the continued legality of abortion (Wagner, 2003). In contrast, pro-choice scholars list the litany of current state based restrictions on abortion and declining number of abortion providers to demonstrate the success of the pro-life movement in reducing access to abortion care.

Direct Action

The rise of the direct action sub-movements within the larger pro-life movement is the subject of the greatest amount of sociological work on the pro-life movement. The first scholar to take up this new sub-movement was Blanchard (1994; 1993); he argues that this development was fueled by feelings of alienation from the agenda of the more mainstream pro-life movement which had begun to focus its efforts to restrict abortion at the state level rather than to seek a full ban. The perceived failure of traditional lobbying tactics and executive regulation to bring about the level of change required to stop abortion led many in the movement to adopt a more aggressive and violent stance in order to stop abortion. A national network developed of social movement organizations engaged in direct action (Blanchard, 1994). These organizations used both violent (including bombing, arson, and harassment) and non-violent (including sidewalk counseling, pregnancy alternative centers, and nonviolent protesting) tactics. Throughout the years the direct-action undertaken by anti-abortion groups would vary and different

social movement organizations would be dominant. In addition individuals within the direct action movement would assume leadership positions not dependent on engagement with a particular social movement organization. The meaning of activism for those involved in direct action would differ sharply from that articulated by activists in earlier studies. The outcomes sought would be the stoppage of abortion services, not simply the legal support for abortion.

Social Movement Organizations and Leaders

As discussed earlier in the review of the theory of social movements, attention to social movement organization is a standard tool of scholars. Morris (2000) writes that this attention fails to recognize the role that leadership plays in movement causation. For Morris, movement leadership is an important complex phenomenon that should be included in studies of social movements. As such, the below discussion addresses what is know about both the organizations and the leadership within the direct action movement.

The first identifiable direct action organization in the movement was the Pro-Life Action League (PLAL) founded by Joseph Scheidler in 1980 after he was expelled as director of Friends for Life due to his support for the use of violence. PLAL, later called Pro-Life Action Network (PLAN) was one of the first groups to advocate violence as a political strategy to thwart implementation of existing laws. In 1989 the group took four thousand aborted fetuses from a Chicago pathology lab and staged highly publicized funerals (O'Connor, 1996). Pat Buchanan described PLAN as "the green beret of the pro-life movement" (Blanchard, 1994 quoting; Vinzant, 1993). PLAN's leader Scheidler is best known as the author of *Closed: 99 Ways to Stop Abortion* (1985), which advised anti-abortion groups to adopt more dramatic tactics, such as picketing physicians' homes

and embarrassing them in public places with demonstrations. While explicitly disavowing violence in his book, the text of the book describes violent tactics with sufficient detail to provide guidance to those that might want to use violence. He is also credited with serving as the central figure in keeping elements of the activist wing of the movement informed about one another (Blanchard, 1994). Scheidler would be the focus of a high-profile case brought by the pro-choice movement (see the subsequent chapter).

Operation Rescue, founded by Terry Randall, is probably the best known of all direct action groups. According to some historians of the pro-life movement, Scheidler helped to foster Operation Rescue to avoid more court suits from clinics and pro-choice organizations (Blanchard, 1994). Breaking with the focus on simply limiting the legality of abortion, Operation Rescue sought to stop the actual provision of services. The group's objective was four-fold: to stop the abortions on the day of the demonstration, to create tension and fear so other clinics would close that same day under sense of threat, to put the pro-choice movement on the defensive, and to add momentum to the pro-life movement. Operation Rescue conducted its first demonstration, called a "rescue," in Nov 1987. Two hundred eleven people were arrested and charged with trespassing and released (Ginsburg, 1998).

The group gained national attention the following year with a series of demonstrations in New York City (O'Connor, 1996). Initial tactics included blockading entrances to abortion clinics to force them to close their doors. Emboldened by their earlier successes Operation Rescue planned the "Siege on Atlanta" to coincide with the 1988 Democratic National Convention. Two thousand protesters blocked the entrances of several abortion clinics located near the convention center. These sit-ins were billed as

"non-violent" and often referenced the work of civil rights activists. The Siege on Atlanta was broadcast nightly on every news station and brought substantial attention to the pro-life movement (O'Connor, 1996). By 1990, according to Operation Rescue figures, over 35,000 people had been jailed and 16,00 had risked arrest in "rescues" (Frame, 1989; as quoted in Ginsburg, 1998:243).

Operation Rescue's most successful action occurred in 1991 with what would be called the "Summer of Mercy" in which Wichita Kansas was under siege for forty-two days as thousands of pro-life protesters converged on the city to blockade its clinics. More than 2,500 protesters were arrested (O'Connor, 1996). For the first time children were used in the blockades to try to cast the police in a negative light for arresting children (Blanchard, 1994). A federal judge eventually issued an injunction ordering Operation Rescue to call off its demonstrations. The Bush administration intervened on behalf of the protesters in an effort to invalidate the order (O'Connor, 1996). Further legitimacy was afforded the group when the Pope met with Terry Randall at the Vatican in November 1991 (Blanchard, 1994).

Initially radical pro-life groups won support for their activities in the Courts. In *Bray v. Alexandria Women's Health Clinic* [115 S. Ct. 753 (1993)], the Supreme Court found that the Ku Klux Klan (KKK) Act could not be used to bar Operation Rescue from blockading the clinic. In a 6-3 decision Scalia wrote that the KKK Act could not be applied to abortion protestors because their activities were not designed to discriminate against women as a class.

Officially Operation Rescue claimed a public position of non-violence. In contrast other direct action groups openly promoting the use of violence. In 1994 when

Operation Rescue refused to sign a justifiable homicide petition disgruntled members formed the American Coalition for Life Activists. This organization produced the "Deadly Dozen" list that contained the names and addresses of thirteen of the most well-known abortion providers. Although federal marshals were immediately dispatched to the homes and offices of those on the list, by January 1996, five of the list had become the objects of shooting and other forms of violence and intimidation (McGeown, 1996; as quoted in O'Connor, 1996:172). Support for the goal of murdering abortion providers was given national visibility when Paul Hill appeared on the Phil Donahue Show defending the killings of abortionists (Blanchard, 1994).

Other organizations that have been important actors in violent direct action include: the Lambs of Christ and Missionaries to the Pre-Born. The Lambs of Christ was founded in 1988 by retired US Army colonel Norman Weslin. The organization is structured on paramilitary lines. On arrest the Lambs refuse to give their names adopting a pseudonym similar to "Baby John Doe." Missionaries to the Pre-Born was established by Assembly of God minister Matthew Trehella. They are the protestant counterpart to the Lambs. Both the Lambs and the Missionaries claim to have a small number of full time activists that can be deployed to demonstrations to blockade or invade clinics (Blanchard, 1994). Rescue America follows the tactics of Operation Rescue and is headed by Donald Treshman.

Another important organization engaged in direct action but taking a very different approach is Life Dynamics. Located in Texas and headed by Mark Crutcher, a former Operation Rescue activist, the organization hopes to harass abortion providers to the point that they quit (Blanchard, 1994). Crutcher authored the *Firestorm: A Guerrilla*

Strategy for a Pro-Life America. In 1993, Crutcher began assembling a national data file on physicians performing abortion to assist attorneys suing abortion providers for malpractice (Blanchard, 1994).

Tactics

Violence, harassment, bombings, arson, vandalism, invasions, and picketing were the routine tactics of the direct action movement Since 1977, the National Abortion Federation has been compiling statistics on incidents of violence and disruption against abortion providers (see **Error! Reference source not found.**). Of note is the rise in total disruptions in 1993 and the high numbers of picketers between 1992-1996 when Operation Rescue was in full force.

The apex of violence was the actual killing of abortion providers. The first shooting at an abortion clinic occurred in 1991 in Springfield, Missouri where two people were injured. In March 1993, Dr. David Gunn was shot to death in Florida. Later that year Dr. George Tiller in Kansas was shot and injured. In July 1994 Dr. John Bayard Britton and his escort, James H. Barrett were shot and killed in Florida by Paul Hill, the man who had advocated killing as justifiable homicide after Dr. Gunn was shot. In December John Salvi III went on a shooting spree in two Brookline, Massachusetts clinics in which two women were shot and killed. In October 1998 in upstate New York Dr. Barnett Slepian was shot and killed in his home.

Table 1: NAF Violence and Disruption Statistics

VIOLENCE TOTAL	*77-88*	*89*	*90*	*91*	*92*	*93*	*94*	*95*	*96*	*97*	*98*	*99*	*00*	*01*	*02*	*03*	*04*	*To Date*
Murder[1]	0	0	0	0	0	1	4	0	0	0	2	0	0	0	0	0	0	7
Attempted Murder	0	0	0	2	0	1	8	1	1	2	1	0	1	0	0	0	0	17
Bombing[1]	24	1	1	1	0	1	1	1	2	6	1	1	0	1	0	0	0	41
Arson[1]	56	8	10	8	19	12	11	14	3	8	4	8	2	2	1	3	2	171
Attempted Bombing Arson[1]	35	2	3	1	13	7	3	1	4	2	5	1	3	2	0	0	0	82
Invasion	222	25	19	29	26	24	2	4	0	7	5	3	4	2	1	0	0	373
Vandalism	220	24	26	44	116	113	42	31	29	105	46	63	56	58	60	48	13	1094
Trespassing	0	0	0	0	0	0	0	0	0	0	0	193	81	144	163	66	23	670
Butyric Acid Attacks	0	0	0	0	57	15	8	0	1	0	19	0	0	0	0	0	0	100
Anthrax Threats	0	0	0	0	0	0	0	0	0	0	12	35	30	554	23	0	0	654
Assault & Battery	46	12	6	6	9	9	7	2	1	9	4	2	7	2	1	7	0	130
Death Threats	65	5	7	3	8	78	59	41	13	11	25	13	9	14	3	7	2	363
Kidnapping	2	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	3
Burglary	20	0	2	1	5	3	3	3	6	6	6	4	5	6	1	9	1	81
Stalking[2]	0	0	0	0	0	188	22	61	52	67	13	13	17	10	12	3	1	459
TOTAL DISRUPTION	*690*	*77*	*74*	*95*	*253*	*452*	*170*	*159*	*112*	*223*	*144*	*336*	*215*	*795*	*265*	*143*	*42*	*4245*
Hate Mail/Harassing Calls	162	30	21	142	469	628	381	255	605	2829	915	1646	1011	404	230	432	102	10262
Email/Internet Harassment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24	70	19	113
Hoax Device/Susp. Package	0	0	0	0	0	0	0	0	0	0	0	0	0	0	41	13	2	56
Bomb Threats	216	21	11	15	12	22	14	41	13	79	31	39	20	31	7	17	7	596
Picketing	775	72	45	292	2898	2279	1407	1356	3932	7518	8402	8727	8478	9969	10241	11348	3445	81184
TOTAL BLOCKADES	*1153*	*123*	*77*	*449*	*3379*	*2929*	*1802*	*1652*	*4550*	*10426*	*9348*	*10412*	*9509*	*10404*	*10543*	*11880*	*3575*	92211
Number of Incidents	184	201	34	41	83	66	25	5	7	25	2	3	4	2	4	10	4	700
Number of Arrests[3]	12022	12358	1363	3885	2580	1236	217	54	65	29	16	5	0	0	0	0	0	33830

Incidents of Violence and Disruption Against Abortion Providers in US and Canada

All numbers represent incidents reported to or obtained by NAF. Actual incidents are likely much higher. Tabulation of trespassing began in 1999 and tabulation of email harassment and hoax devices began in 2002.

1. Incidents recorded are those classified as such by the appropriate law enforcement agency. Incidents that were ruled inconclusive or accidental are not included.
2. Stalking is defined as the persistent following, threatening and harassing of an abortion provider, staff member, or patient away from the clinic. Tabulation of stalking incidents began in 1993.
3. The "number of arrests" represents the total number of arrests, not the total number of persons arrested. Many blockaders are arrested multiple times.

Source: (National Abortion Federation, 2004)

Direct Action Activists

The violence and intimidation associated with the direct action sub-movement drew attention to the abortion clinic as the key site of contestation between the movements. As such, the clinic blockades and sieges of the pro-life movement and the defenses mounted by the pro-choice movement attracted much journalistic interest as well as some sociological inquiry. The personal histories of those engaging in direct action on behalf of the pro-life cause are told in several books (Faux, 1990; Gorney, 1998; Hertz, 1991; Korn, 1996).

Jacoby (1998) argues that those engaged in violence are different from other activists in fundamental ways. Blanchard (1994) found that the nature of an individual's involvement in the direct action pro-life movement is a function of sex, occupation, and social class. The crucial factor in determining the degree of activism of an individual in the movement is the degree of encapsulation, defined as the lack of ties to individual and groups that hold opposing or even disinterested perspectives on the issue of abortion. Blanchard argues that the majority of the most violent anti-abortionists, the arsonists and bombers, have been self-employed under age 35 males with rigid fundamentalist beliefs. These people differ from the upper-middle class professionals who dominate the organizations devoted to education and lobbying. Picketers, in contrast tend to be predominately working class males and homemakers, and while more women are engaged in this activity the leadership tends to be male.

In his critique of theories of New Social Movements, Pichardo (1997) argues for the application of New Social Movement theory to an understanding of conservative movements. The attention paid to the direct action movement and the meaning given to

their action by the movement members begins to answer this challenge. Pichardo notes that it is the issue of identity that is the unique characteristic of modern movement theory. While only touched upon by scholars of the direct action movement of the pro-life movement, it affords the potential for further sociological inquiry. In her work on pro-life activists Maxwell (2002) provides greater insight into differing meanings of movement engagement for activists, using social movement theory to help explain actions. Unlike Ginsburg and Luker, Maxwell found that the individualized meaning of abortion for pro-life activists was often articulated as personal obligation to God. Maxwell also identifies the role direct action can play for some women who are seeking absolution for their own abortion experiences.

O'Connor (1996) argues that *Roe* drew organized religion into the political fray uniting Evangelical Christians, Roman Catholics, and Orthodox Jews together in their opposition to abortion. This interpretation, while simplistic, represents the extent to which anti-abortion position and religiosity have been fused in the common understanding of abortion. Himmelstein and McRae (1984) summarized the research on anti-abortion movements ten years following *Roe*. He argued that religious networks were crucial to the recruitment into high-profile more radical groups. Recent work by Munson (2004) on the relationship between religion and anti-abortion activity explores how abortion opposition is more than just a religious position but can be understood as religious practice.

Blanchard (1994) seeks to explain how the topics of religious and cultural fundamentalism relate to the anti-abortion movement. For him, cultural fundamentalism is, in large part, a protest against social change. It involves a literal interpretation of the

bible complemented by a belief in atonement. Whether it is Catholic, Protestant, or Morman fundamentalism, the goal is to return religion as the central social institution. There is a general opposition to intellectualism, modern science, and communism. For Blanchard (1994) six basic commonalities exist between Protestant, Catholic and Mormon fundamentalism which influence how anti-abortion activities unite across the religious sects: 1) the belief in one final truth, 2) an external source of truth (i.e. the bible and Church dogma, 3) a dualistic belief system, 4) a traditional family ethic, a justification for violence and 6) a rejection of modernism (i.e secularism). Each of these would play a major role in the rise in anti-abortion direct action.

Several social movement scholars link the pro-life direct action sub-movement to larger conservative movements in the United States. In her work on the apocalyptic narrative of pro-life politics, Mason (2002) tries to explain how the apparent contradiction being support for murdering an abortion providers and identifying as "pro-life." Mason understands the extremist position within the pro-life movement as part of a larger effort to reestablish the United States as a Christian nation [see also Berlet and Lyons (2000) on right-wing populism in America as well as Diamond (1995; 1998)]. Berlet and Lyons (2000) use the phrase "repressive populist movements" to describe populist movements that combines anti-elite scapegoating with efforts to maintain or intensify systems of social privilege and power. They define "the people" in ways that are inclusive and challenge traditional hierarchies as well as in ways that silence and demonize oppressed groups. Central to these movements is the ideology of "producerism," a doctrine that champions the so-called producers in society against both unproductive elites and subordinate groups defined as lazy and immoral, thus facilitating

the use of demonization and scapegoating as political tools. "Right-wing" repressive populist movements are movements that are motivated or defined centrally by a backlash against liberation movements, social reform, and revolution.

According to Berlet and Lyons (2000) apocalyptic fears and millennialist[6] expectations are central to American right-wing repressive populist movements. Apocalypticism is the anticipation of a righteous struggle against evil conspiracies. It is a central narrative in American religious, secular, political and cultural discourse. As such, Berlet and Lyons (2000) contend that it is inaccurate to portray these movements as "lunatic fringe" or marginal extremist. Rather, right-wing populists are dangerous not because they are crazy zealots but because they are not. The tendency to label these movements as extreme fails to recognize the direct ideological, organizational and economic links between right-wing populism and mainstream political forces.

How the rhetoric of the anti-abortion movement leads to the adoption and use of more extreme violent action in real life is explored autobiographically by Reiter's (2000); he recounts his experience as an undercover journalist who finds himself amongst activists who advocate killing of abortion doctors as "justifiable homicide."

Outcomes

According to Killian (1972), the more violent wing of a social movement can have several divergent effects. It may: increase the bargaining power of moderate leaders; provide a corrective to illusions of progress, identify unresolved issues and define new ones, radicalize a segment of the membership and polarize the movement and its opposition, focus the attention of the opposition and the bystander public on new issue

[6] Millenniumism is a special form of apocalyptic expectation. Most contemporary Christians fundamentalists believe that when Christ returns, he will reigns for a period of 1,000 years—a millennium.

or evoke extreme repression from the opposition. Blanchard (1994) contends that all these effects were found in various organizations within the anti-abortion movement at different times and stages of its development.

O'Connor (1996:179) posits that "clearly, the radical rescue wing of the right-to-life movement has hurt that movement." In a study of Operation Rescue, Johnson (1997) found that inconsistencies between the group's framing regarding nonviolence and its tactical actions created inconsistencies that muted the prospect of broader support. Wilcox and Gomez (1990) use data from election surveys to demonstrate that while the pro-life movement was able to gain public acceptance for its anti-abortion positions those mainstream supporters did not endorse the full Christian right agenda. Youngman (2003) argues that the failure of Operation Rescue to expand its frame beyond abortion to include pornography and gay rights demonstrates the limited success of the efforts of this organization. These perspectives of movement failure are based on the idea that the role of violence was to change the general public's position on abortion, to obtain changes in the political process, or to garner support for a larger pro-life agenda. Such a perspective fails to comprehend both the motives of those that engage in violence as an act and the implications of that violence for abortion provision.

The belief that the direct action activities were largely unsuccessful also reflects a myopia within social movement theory that tends to investigate larger organizations and actions and ignore the actions of single actors. However, in the case of anti-abortion direction the role of single individuals is critical to the understanding of the effect of the larger social movement. Blanchard (1994) argues that the impact of the actions on the public and on politics is not necessarily related to the size of the organization. Rather the

more radical the activities of the organization the more attention the actions receive from the press. Thus a single bombing is given more media time than the actions of the NRLC (Blanchard, 1994). Blanchard (1994) posits that as a result of the violence the public began to perceive the abortion issue as a more volatile one. In his refinement of the political process model, Meyer (1999) notes the importance of studying the hard cases, moving away from the mass society approach to understanding movements. As an example he cites the importance of understanding people like John Savli, whose murder of an abortion provider had enormous implications for both the pro-choice and the pro-life abortion social movements.

The question of how the larger pro-life movement dealt with its radical wing is the subject of some sociological disagreement. Barkan (1986; as cited in Blanchard, 1994:76) contends that moderate social movement organizations often denounce radical social movement organizations for actions that threaten potential sources of support. For Blanchard the lack of clear distancing of the moderate groups from the radical ones in the anti-abortion movement challenges this theory. For example, the Catholic Conference blamed bombings on the existence of clinics. While the NRLC eschewed the use of violence it tacitly endorsed the bombings and arsons. When Dr Gunn was killed the NRLC was finally unequivocal in their denunciation of the violence (Blanchard, 1994). However several new organizations within the movement developed to support and defend the murders.

One accepted effect of the direct action tactics of the pro-life movement has been a decline in the number of abortion providers in the U.S. (Forrest & Henshaw, 1987; Grimes, 1992; Henshaw, 1991, , 1995; Henshaw & Finer, 2003; National Abortion

Federation, 1991). In 2000 fewer than 2,000 abortion providers remained in the United states and 87% of counties are without a recognized abortion provider (Finer & Henshaw, 2003). Rigorous studies on how violence affects a physician's decision whether to offer abortions have not been done. To date, one of the liveliest, albeit biased, accounts of the effect of violent direct action tactics on the clinics themselves is presented in a book by Baird-Windle and Bader (2001). One of the authors is herself an abortion clinic owner who experienced severe harassment at work and home as well as had her clinic burned to the ground and insurance and leases denied. The book also relates the stories of abortion clinics all over the country where harassment, violence, arson, and bombings occurred.

Framing and Discourses

The language used within the anti-abortion movement has enormous implications for the meaning of abortion. Three frames have dominated the field of anti-abortion discourse. The most widely used frame is that of life as embodied in the fetus. A larger cultural frame is also used which comprises notions of "family values" and newer apocalyptic narratives linking abortion to overall societal destruction. The newest frame of women's health has only recently emerged and consequently has received less prominence than the other two.

Life and the Fetus

The best articulation of the anti-choice position was produced by John Noonan (1970), which created what Condit (1990) calls a "heritage tale" in which opposition to abortion was tied to the historical value of the country, namely the preservation of life. In this way the major constitutive value grounding the anti-abortion position was "Life." The medical knowledge created at the time of criminalization would be accepted as a

taken for granted. While the formation of the opposition's rhetoric was a critical component of the contested nature of abortion a detailed discussion of the moral arguments on which it is grounded is beyond the scope of this paper.

One feature of the oppositions' arguments that is important to this discussion is the way in which science was used to justify opposition to abortion. Condit (1990) argues that from the late sixties onward the major rhetorical effort of the anti-abortion movement was to link the terms "fetus" with "life." The concrete term "fetus" was bolstered through claims that science had discovered that the fetus was a human being from the time of conception. In this way the opposition to abortion claimed greater authority than just religious morality, by engaging science.

Perhaps the most successful discursive strategy of the pro-life movement is the use of pictures of aborted fetuses which highlighted the human-like features of the physical appearance of the fetus. Scholarly interest in this subject surfaced in the 1980s after the release of *The Silent Scream,* a widely distributed film which purported to show a fetus screaming while being aborted under ultrasound. The film was important both for its visual imagery but also for its symbolic meaning. The film was produced by Dr. Bernard Nathanson, one of the founders of the NARAL (the largest national pro-choice organization that is discussed at length in the subsequent chapter) and now a pro-life activist. The importance of the fetus to the pro-life movement as visual construction was first explored by Petchesky (1987) who argues that these images fundamentally changed the meaning of abortion in the public discourse.

The life frame is often put up against the choice frame of the opposition. For example, in 1992[7] to affect the national presidential election, the Arthur DeMoss Foundation began a national television campaign called "Life, What a Beautiful Choice" in an attempt to neutralize the negative publicity around the pro-life position (O'Connor, 1996). The "Life" campaign was also designed to reclaim the term "choice" which had been introduced onto the public agenda by the pro-choice movement.

Culture War

Abortion is often called the "culture war"(J. D. Hunter, 1991) referencing a battle between "family values" and liberalism. For Williams (2002), the term "family value" has come to be a well-understood symbol for a collection of political issues centering on sex, gender and family relations, in which abortion is featured prominently. However such a definition limits greater understanding of the role of this phrase. Williams argues that the family values agenda and its vehement adherence by the Christian Right has ideological coherence beyond the substantive issue of sex. Rather there is an underlying concern with boundaries, their clarity and the structure of meaning for society in general. Because religion gives boundaries moralized meaning, social arrangements predicated on a lack of distinction and difference are a moral problem. The symbolic boundaries regarding gender are morally necessary for society. In this way family values discourse resonates within the ideology of boundary maintenance (Williams, 2002) within what I call the hegemony of the female as natural reproducer.

These notions of boundaries between right and wrong, good and evil are also articulate in apocalyptic narratives which see abortion as symbolic of societal destruction.

[7] Although the Pro-life movement experienced a series of defeats in the 1992 presidential elections their loss of control of Washington was short-lived. In 1994, the 104th Contract with America Congress was elected.

Pro-life historians build analogies between slavery, the holocaust, and abortion (Noonan, 1970). As the editor of a book on the future of the pro-life movement explains:

> The legalized execution of 16 million unborn children bears powerful witness to the infinite capacity of the human heart for cruelty and self-deception. As a culture, we have broken our moorings and set sail on the bloody seas of mass extermination.
>
> (Andrusko, 1983:3)

When the focus is shift from the life frame to the social destruction frame the apparent inconsistency between being "pro-life" and support for those who kill in the name of "pro-life" is clarified. Mason's (2002) work on apocalyptic narrative argues that there is internal consistency of the logic based on a higher order value of stopping abortions at all costs and saving society from god's wrath.

Women's Health

While not identifying with the pro-life feminists, the larger pro-life movement has also articulated a woman-centered perspective in its pronouncement that abortion is harmful to women. In describing this perspective, Cannold (2002) argues that this approach offers an alternative to the fetus-centered strategies that dominate the pro-life movement. Rather than judge women as villains for having abortions women are seen as victims of an abortion industry. Taken up by the pro-life organization Women Exploited by Abortion (WEBA)[8] the foundation for this argument is that abortion has negative consequences for women. Its frame "Women Deserve Better" represents a women-centered position that can effectively respond to claims that the pro-life movement is anti-woman.

[8] WEBA was founded by Nancyjo Mann who felt extreme remorse for her abortion (J. D. H. Hunter, 1994).

WEBA focuses on the personal-lived experiences of women who have had an abortion and subsequently renounced that decision. In this way, WEBA can be seen as an embodied health social movement, seeking to challenge the existing medical and scientific knowledge and practice about abortion. Brown et al (2004) argue that a characteristic of embodied health movements is collaboration between scientists and health professionals in pursing action. However, what defines science and health professional is at the heart of the abortion debate. In recent years, anti-abortion activists have sought to create a body of scientific knowledge about the negative consequences of abortion led predominantly by the work of Reardon and colleagues at the Elliott Institute (Burke & Reardon, 2002; Reardon, 1987, , 1996).

Summary

This assessment of the literature pertaining to the pro-life movement reviews two activist strategies: mainstream political engagement and direct action. For each the discussion surrounds social movement organizations, tactics, outcomes as well as the meaning of for activists. Finally the chapter examines the three main frames used by the pro-life movement: the fetus as life, the culture war, and women's health.

In the decade following *Roe* the pro-life movement was comprised mainly of social movement organizations that sought political change, first at the national level and subsequently at the state level when national efforts failed to yield a constitutional amendment to prohibit abortion. While initially Catholic in composition, these organizations are increasing affiliated with Evangelical Christianity. In addition formation of pro-life PACs moved opposition to abortion as single issue politics, aligning the pro-life movement with the New Right and other conservative social movements.

These efforts were rewarded when the Republican Party adopted an anti-abortion platform and promoted the election of pro-life candidate Ronald Reagan as president. Both Reagan and George H.W. Bush used the power of the executive branch to forward anti-abortion policies and law. One ongoing legacy is the change in the composition of the Supreme Court which began to allow abortion restrictions based on a "undue burden" standard rather than maintaining abortion as a fundamental right.

What literature exists on these early activists has identifies fundamental differences in world views about the role of women and motherhood. Pro-life scholars, however, challenge this interpretation centering early opposition to abortion in concerns for the fetus and the role of religion.

Incremental changes in abortion law at both the state and the national level were unsatisfactory to a subset of the movement that saw stopping abortion as absolute. From this dissatisfaction and the escalating rhetoric that abortion represented both murder and a challenge to God's design, the direct action wing of the pro-life movement emerged. The goal was not political change but the halting of abortion services. As such the focus of direct action was the "abortion clinic" and the "abortionist" rather than the political process. The social movement organizations that comprised this movement would be equally as important as the few lone individuals whose actions would define this submovement. Bombings, arsons, and harassment would continue to escalate until several murders were committed in the "name of life." The media paid increasing attention to these extremists and the conflict over abortion was associated with the potential for violence. Work examining the activists engaged in the direct action

submovement identifies the role of religion as well as how abortion opposition serves as redemption for women's abortion experiences.

One claim made by both the activists doing mainstream political engagement and those involved in direct action was that the fetus was life. The suppositions behind this claim have their roots in the ideology and hegemony created as medical knowledge during the physicians' opposition to abortion in the mid nineteenth century. A second frame, the culture war, is also reminiscent of the race/ethnicity rhetorical language used at that time. The third frame, women's health is newer and reflects some successes of the women's movement's which focused attention on the woman as a subject of the abortion debate.

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CHAPTER 7: PRO-CHOICE SOCIAL MOVEMENT(S)

In comparison to the pro-life movement, the pro-choice movement receives less scholastic and journalistic attention. Staggenborg (1988; , 1991), who studied the social movement organizations that comprise the pro-choice movement, provides the most comprehensive sociological discussion to date. According to Staggenborg no demobilization of the abortion repeal movement occurred after the passage of *Roe*. Rather the growing strength of the countermovement required the institutionalization of the pro-choice movement and the use of tactics geared at maintaining abortion legality through legislative and judicial processes. For Staggenborg the professionalized organizational structure of the pro-choice movement with its combination of national institutionalized tactics and its grassroots advocacy explain the success and survival of the movement. However, the agenda for the pro-choice movement is seen as being set in reaction to the successes and tactics of the pro-life countermovement. The below discussion focuses on three components of social movement analysis: social movement organizations, tactics, and framing.

Social Movement Organizations

Central to the story of the pro-choice movement is the role of the social movement organization NARAL Pro-Choice America (name established in 2003) which was initially founded as the National Association for Repeal of Abortion Laws and subsequently changed its name to the National Abortion Rights Action League and then the National Abortion and Reproductive Rights Action League. Two other social

movement organizations would be critical to the successes of the pro-choice movement: Planned Parenthood and the American Civil Liberties Union Reproductive Freedom Project. In conjunction with Religious Coalition for Reproductive Freedom, Catholics for a Free Choice would seek to articulate religious support for abortion to counter the growing strength of the anti-abortion position being articulated in religious terms.

While NARAL was strongly influenced by the women's movement, there was not always shared agreement between the feminist movement and the single issue pro-choice movement. The agenda of a larger "reproductive rights movement" which sought support for abortion funding as well as childcare was often sacrificed to single issue abortion politics out of necessity to quickly counter the successes and tactics of the pro-life movement. The extent to which the pro-choice movement responded the successful passage of the Hyde amendment restricting poor women's access to abortion financing is contested within the movement (see Fried, 1990; Stetson, 2001 for discussion of inadequate response).

The visible threats to abortion mounted by the pro-life movement in the mid 1980's spurred recruitment into the pro-choice movement, galvanizing grassroots and political involvement. NARAL's "Impact 80's" strategy sought to directly respond to the growing political strength of the opposition by convincing candidates that there were single-issue pro-choice voters.

Tactics

Although the pro-life movement viewed itself as successfully having elected Reagan as president, there remained insufficient support for the pro-life agenda in Congress. The pro-choice movement raised concern over the ability of the

countermovement to forward its agenda by changing the composition of the courts. In 1987 open warfare broke out over the nomination of Robert Bork for the Supreme Court. The pro-choice movement galvanized opposition eventually defeating Bork, resulting in the appointment of abortion-rights moderate Anthony Kennedy, who, while not willing to overturn *Roe* accepted new restrictions on abortion in the 1989 *Webster v. Reproductive Health Services* decision.

The *Webster* decision began a new round of conflict between the pro-choice and the pro-life movements. In anticipation of a court ruling, the pro-choice movement organized a massive march on Washington in April 1989, attracting over 300,000 abortion rights supporters. Throughout this period NARAL continued to grow in size and strength. NARAL's membership grew to an unprecedented 400,000 in 1990 allowing the group to pump money into local grassroots activities. Central to the success of NARAL was its use of direct mail techniques for raising money.

In 1991 the most sweeping abortion regulation law was being heard by the Court in *Casey*. In addition to filing amicus briefs the pro-choice movement sponsored the March for Women's Lives on April 5, 1991, drawing between 500,000 and 700,000 marchers (O'Connor, 1996). In 1991, feeling that public support for abortion was high; the liberal Alan Cranston (C-CA) introduced the Freedom of Choice Act (FOCA) in the US Senate. A companion bill was introduced in the House by Don Edwards (D-CA). It never made it off the floor of either branch. Thus while there was insufficient support to overturn *Roe* there was also insufficient support to codify Roe through federal legislation.

The momentum of the pro-choice movement culminated with the election of President Bill Clinton in 1992. Just two days after his inauguration, on the eve of the

twentieth anniversary of the *Roe* decision, he issued several executive orders overturning five abortion restrictions put in place by prior Reagan/Bush administrations. The first of these was the repeal of the domestic gag rule on abortion counseling, the second lifted the ban on federally funding for fetal tissue research, the third directed the Secretary of Health to review the ban on importation of RU486, the fourth lifted the ban on privately paid for abortions in overseas military hospitals, and the fifth eliminated the global gag rule also known as the "Mexico City Policy." Clinton also supported the inclusion of abortion in proposals for national health care. During his term he appointed two pro-choice judges to the Supreme Court: Stephen G Breyer and Ruth Bader Ginsburg.

As the pro-life countermovement increased its engagement in direct action, differences arose within the pro-choice movement as to how best to respond. Those from the women's community with a history of direct activism preferred retaliatory direct action while the institutionalize leadership of the movement sought solutions through injunctions and the use of police. A preference was given for activists to serve as "clinic escorts" rather to engage in more confrontational "clinic defense" (see Fried, 1990).

The increasing violence against abortion clinics and the failure of the Courts to uphold injunctions against violent protesters led pro-choice interest groups to lobby for Congressional action. As lobbying was initiated Dr. David Gunn was shot and killed in March 1993, shocking the nation and prompting Attorney General Janet Reno to call for federal legislation to protect women from clinic violence. As the Freedom of Access to Clinic Entrances Act (FACE) was being debated in Congress, two additional physicians were shot (one wounded and one killed). These killings prompted the quick approval of the federal legislation.

In January 1994 the Supreme Court decided *National Organization of Women (NOW) v. Scheidler* in which NOW argued under the RICO anti-racketeering statute that pro-life activities directed at clinics were part of a massive conspiracy to drive abortion clinics out of business. The Court found unanimously that economic motive was not critical to RICO for there to be a conspiracy to negatively affect business. In this way, the RICO statute could be applied to those organized efforts to shut down abortion clinics. Although financial awards were granted to abortion providers, no real transfer of funds occurred as origanizations disbanded and individuals declared bankruptcy.

During the short tenure of a democratically-controlled Congress with a supportive presidency, the Congress failed to pass more pro-choice legislation. In 1993 The Freedom of Choice Act became bogged down in debates about minors access to abortion and public funding for abortion under Medicaid; two continually sticky points for the pro-choice movement. With the belief that FACE and the Courts decision in *Schiedler* would curtail violence, few members of Congress were willing to take high-profile positions in support of abortion rights. In 1994, the Pro-choice movement lost any opportunity when Newt Gingrich and the Contract with America 104th Congress swept into Washington.

With a few exceptions, most scholars of social movement activity and abortion have failed to see the importance of developments within U.S. medicine: that is the activities of both pro-life and pro-choice health workers who attempt to influence their colleagues on this emotionally charged issue. The rise in violence is understood to have prompted the activation of a new pro-choice physician counter-counter movement. The creation of the organization Medical Students for Choice is seen as a turning point in the

reengagement of physicians as a social movement player in the current fight over abortion (Joffe, Anderson, & Steinauer, 1998). The uneasy alliance between physician-led activism and feminist-led activism, which has historically been critical of physician power and dominance, is provided by Joffe, Weitz, and Stacey (2004).

Framing

The overall successes and failures of the pro-choice movement strategy is explored by Saletan (2003) in his work on how conservatives won the abortion war. Of particular interest is the adoption by the pro-choice movement of the NARAL "Who decides" frame in which support is sought not for abortion rights but for keeping the government out of the decision. While this frame was successful in gaining support for the legality of abortion right it fails to generate more broad-based support for the pro-choice agenda for unrestricted access to abortions.

When the pro-life movement introduced the *Silent Scream* the focus of the debate shifted to the cultural arena. The pro-choice movement sought to reframe the debate by encouraging women to raise their voices thereby shifting the debate away from the fetus to the woman (see Bonavoglia, 1991; Ebersole & Peabody, 1994; Hoshiko, 1993; Jacob, 2002; Kushner, 1997). NARAL's campaign "Abortion Rights: Silence No More" served as a formalized version of the speak-out. A critical vehicle for recruitment and maintenance of activism in the pro-choice movement remained the retelling of the experiences of women who underwent illegal abortions [see Messer and May (1988) Miller (1993)]. During this period physicians themselves also sought to tell their stories as a means of humanizing abortion (see Poppema & Henderson, 1996; Sloan & Hartz, 1992)

How abortion is taken up by the public discourse is an area of potential rich study for those interested in the effects of the social movements. Condit (1990) provides the first look into how discursive formations are used to forward a particularized understanding of abortion. Press and Cole (1999) further this work by their study of how women respond to representations of abortion on television. The use of visual imagery by both the pro-choice and the pro-life movement is explored by Shrage (2003). Myrsiades (2002) examines the culture of abortion in literature, law, cartoons, and rhetoric while Williams (2003) has looked at political cartoons. The relationship between the way in which abortion discourse is shaped by the public perspectives on the role of the state is the subject of the sociological work by Ferree and colleagues (2002). Using theories of framing, Esacove (2004) demonstrated how framing and reframing occurred as a dynamic interaction between the pro-life and the pro-choice movement, in an effort to construct a particular understanding of medical practice, so-called "partial birth abortion."

Perhaps one of the most under told stories of the abortion movements is the role of women of color who often resisted the single-issue orientation of the pro-choice movement. In her work on the subject, Nelson (2003) helps connect the reproductive rights movement with resistance to the eugenics movement and efforts to address sterilization abuse. Numerous scholars have raised concern that the grounding of abortion as an individual private decision further shaped the direction of the movement away from the larger feminist movement (Petchesky, 1984).

The issue of whether pro-choice movement is a health social movement has not been addressed in the literature. Clearly it involves both a health condition, pregnancy,

and a health care service, the abortion. However, for many in pro-choice social movements it is the legal right, not the health issues that is the goal of social movement action. In their work on embodied health movements, Brown and colleagues (Brown et al., 2004) present a new theoretical approach (see above discussion) which introduces the body as central to understanding social movements. Like the breast cancer environmental movement they explore the body is central to the pro-choice movement. "My body, my life, my right to decide" is the most frequently chanted mantra of the pro-choice movement. What is unique about abortion is that it is the unaffected that predominantly make up those within the movement voicing this claim. Rarely is the pregnancy or abortion experience as embodied part of the public claim. In the early days of the movement, and amongst those aging women within the movement, the experiences of the illegal abortion are central to their activism. Currently radical components of the pro-choice movement have tried to develop an "I'm not sorry" campaign in which women reclaim their abortion experience. This frame, however, has not had mass appeal.

The environmental breast cancer movement constructed the body as politicized collective illness through a critique of the medical objectification of the female body. The notions of medicalization are seen as complicated and contradictory for the pro-choice movement. Brown and colleague also argue that the environmental breast cancer movement frames the bodily experience of breast cancer as linked to a social structure that exposes women's bodies to unequal environmental burden. At stake in the abortion movement are several claims of the body against the social structures. For example, unequal power dynamics expose women to greater risk of pregnancy and thus increase their need for abortion. The pro-choice movement continues to have an uneasy

relationship to the reality that women of color and low income women need more abortion services. Instead, the pro-choice movement prefers to highlight the statistics that all women need abortion. One of the most successful campaigns undertaken by the National Abortion Federation is the "Sister, Daughter, Mother...a few of the names women who've had an abortion deserve to be called."

Pro-Abortion—The Missing Submovement

Splits as well as ideological and tactical disputes are normal parts of the process of social movement development. Such mitosis may facilitate movement growth and development and bring in new constituencies (Blanchard, 1994). This progression is particularly visible in the pro-life movement where some groups have continued to call for the elimination of all abortions and others have supported abortion in limited circumstances. A point of interest for those interested in progressive social movements is the failure of the pro-choice movement to make such adaptations. While new organizations have appeared they have not challenged the ideological frames presented by the original pro-choice movement that forwarded and support the framework for abortion laid out in the *Roe* decision.

Scholars of the movement(s) and countermovement(s) surrounding abortion argue that they do not share a common world view and that there is a "master frame" under dispute (seeGinsburg, 1989; Luker, 1984). At first glace it might appear that the contested nature of abortion demonstrates that there is no single "taken-for-granted" meaning of abortion itself. As such no hegemony is thought to exist and no one abortion ideology is seen as supporting a particular set of institutionalized power arrangements. This notion that abortion itself is without a universal understanding, reflects the

hegemony of "abortion is problematic". Both pro-life and pro-choice ideologies are grounded in similar understandings of the role of women in reproduction. The contested nature of abortion, does not seek to disrupt this understanding and thus there is no fundamental challenge to the hegemony of the normality of reproduction. Support for this assertion can be found in the complete absence of a pro-abortion submovement. Although the pro-life movement has attempted to paint the pro-choice movement as "pro-abortion," it is a label that does not stick. The pro-choice movement does not advocate for abortion, rather it advocates for the right to choose. This distinction is important and while pro-choice and pro-life movements reflect differing ideologies they share a common hegemonic understanding of abortion as problematic.

Summary

As this discussion of the pro-choice movement demonstrates far less scholastic attention has been paid to studying this movement than its countermovement, pro-life. The answer to the question of why is only speculative. One explanation might be the lack of a radical movement like the direct action wing of the pro-life movement whose tactics were extreme enough to warrant interest by both journalists and scholars. Second, many of the scholars who have studied abortion tend to have more pro-choice leanings. As such, it may be easier to study the "other" than themselves. Third, the pro-life movement has been more open to involvement of scholars because conversion is often a purposeful agenda of the work. In contrast the professionalization of the pro-choice movement may make it less accessible to an outsider.

Abortion social movement would seem ideal for a gendered social movement analysis. Ironically a book dedicated to this subject Gender and Social Movements

(Kuumba, 2001) fails to even include "abortion" as a topic in its index. While a few early scholars (see Ginsburg, 1989; Luker, 1984) have examined the relationship between pro-life activity and gender, no scholars has applied a gender lens to the pro-choice movement. Perhaps because pro-choice is a taken for granted "women's social movement" the way in which the pro-choice movement is gendered has not received attention.

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CHAPTER 8: SUBMITTED ARTICLE

"PRO-CHOICE AND PRO-LIFE MOVEMENTS"

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Abortion is one of the most contested social issues in the United States. Despite its recognized status as a polarizing force in politics, a relatively small number of sociologists have studied the social movements that sustain the abortion debate. As a result, the topic of abortion social movements, while widely written about by journalists, is often under theorized. The following review summarizes the study of movements supporting and opposing abortion rights as studied by sociologists and other social scientists, predominately in the United States with some attention to the changing international dimensions of this debate.

Social movements that take up the issue of abortion are often thought of as resulting from the 1973 Supreme Court decision *Roe v. Wade* [410 U.S. 113] recognizing a constitutional right to abortion. However, social contestation over abortion predates this decision with two periods of high social movement activity: the physician anti-abortion movement of the mid 1800s and the abortion rights reform/repeal movement of the 1960s.

A number of scholars, most notably Mohr (1978) and Luker (1984) argue that the early physician anti-abortion movement was part of a larger professionalizing project within organized medicine. Formally-trained physicians sought to rid the profession of practitioners without such training, as well as lay midwives who were the main providers of abortion to women. In opposition to abortion regular physicians could distinguish themselves from other unregulated practitioners. Because of its capacity to both control and distinguish the profession, abortion became a high priority for the American Medical Association (AMA) formed in 1847. In many ways the AMA can be thought of as the first abortion-related social movement organization in the U.S. In large part due to the

anti-abortion campaign of the AMA, abortion became illegal in every state by 1900. [See Stormer (2002) for a Foucaultian analysis of the early physician opposition to abortion.]

Smith-Rosenberg (1985) examines the cultural context in which the medical profession's crusade against abortion occurred. In the mid-1800s, the transition to smaller family size evident among society's most affluent and influential groups contrasted with the more prolific childbearing of recent immigrants. That white, married, Protestant, middle and upper class women used abortion to space and limit their number of children concerned the elite class that comprised the medical profession. The need for social and ideological control over reproduction helped justified a medical crusade against abortion.

There was no organized countermovement to the first anti-abortion social movement. Although the dates of the anti-abortion movement coincide with those of "first-wave feminism," the early women's movement sought to articulate disparate male-female relationships in alternative language and sexual imagery rather than support for abortion rights (Smith-Rosenberg, 1985). They endorsed "voluntary motherhood," not through abortion but through abstinence and control of men's sexual activity.

Abortion did not reappear on the larger public agenda until the 1960s, when both the medical community and the general public became increasingly frustrated with the inability of most American women to obtain a legal abortion. The works of historians Garrow (1998) and Hull and Hoffer (2001) provide details of the development and tactics of the reform/repeal abortion rights movement. Initially efforts sought to reform laws by allowing more conditions under which a physician could perform an abortion, e.g., when the pregnancy was the result of a rape or when the developing pregnancy suffered from a

genetic anomaly. Although these claims had wide-spread public appeal, they comprised only a small number of reasons why women sought abortions and thus few women qualified for abortions under these reform conditions. Eventually the limitations of the reform agenda would give way to a demand for the full repeal of abortion laws.

Two medical crises appeared in the 1960s that re-engaged physicians in the debate over abortion: The use of the drug thalidomide by pregnant women (as in the Sherri Finkbine story), and the exposure of pregnant women to German measles (rubella) (Hull and Hoffer, 2001). Thalidomide was never approved for use in U.S. but it was used by many American women as a tranquilizer. When used in early pregnancy thalidomide causes gross fetal deformities. Similarly, women exposed to German measles in early pregnancy were also at higher risk of genetic abnormalities. An epidemic of German measles in the mid 1960s resulted in many physicians being asked to perform abortion. Joffe's (1995) work on physicians who practiced prior to and at the time of *Roe* illuminates the reasons for physician's additional engagement in the efforts to fully repeal abortion laws rather than simply reform them. Both the witnessing in hospital emergency rooms of the disastrous results of illegal abortion and the lack of clarity regarding the legal status of the few in-hospital abortions physicians were providing served as motivation for social movement action.

In addition to the role of physicians in the reform/repeal efforts, feminist scholars highlight the role of the 1960s "second wave" women's movement in the pressure for full abortion law repeal. The claim was that women deserved the right to have an abortion for the reasons of their choice. Women engaged in both political action geared at changing the laws as well as in directing women to safe illegal abortion providers and in

some cases performing safe illegal abortions themselves. The history of both the Society for Humane Abortion and the Jane Collective contribute to an understanding of the efforts of feminist activists at this time.

The efforts to repeal abortion laws through the states' legislative processes experienced increased resistance, in part due to rising opposition from the Catholic Church. As such, the leaders of the reform/repeal movement began to prefer a judicial strategy challenging the constitutionality of abortion laws. The path of the case that would become associated with the right to legal abortion, *Roe v. Wade,* is discussed in several books, most usefully by Garrow (1998) and Luker (1984).

The *Roe* decision served as a catalyst for two new umbrella social movements: supporters and opponents of the right to legal abortion as articulated in *Roe*. The titles for these movements are contested between the movements but they are commonly referred to as the "Pro-life Movement" and the "Pro-choice Movement."

Within social movement literature, the Pro-life Movement can be understood as a countermovement developing in response to success of the abortion law reform/repeal movement culminating in *Roe*. In the 1970s changes to the tax code facilitated the formation of political action committees (PACs) and thus the opportunity for the Pro-life Movement to actively engage in the political arena. Pro-life PACs were formed to target vulnerable abortion rights supporting politicians using single-issue voting, thereby aligning the growing Pro-life Movement with the newly developing Christian Right. The merger of the Pro-life Movement and the New Right resulted in the adoption of a pro-life platform by the Republican Party and the election of Ronald Reagan as a pro-life candidate for president in 1980.

In addition to seeking to affect national politics the Pro-life Movement maintained a state-based strategy to limit access to abortions through the passage of laws in state legislatures. The first regulations to be upheld by the Supreme Court (1977) were state-based restrictions on the use of Medicaid funding to pay for abortions for poor women; the Court would eventually uphold the federal prohibition on Medicaid funds known as the "Hyde Amendment" in 1980. Until 1989 further restrictions were struck down at both the state and the district court level, based on the *Roe* decision. In 1989 the Supreme Court heard *Webster v. Reproductive Health Services* [109 U.S. 3040] challenging the constitutionality of Missouri's restrictions on abortion. When *Webster* was announced, the Court fell short of overturning *Roe*, but a slim majority upheld every restriction of the law.

With the green light from the Court that some state-based restrictions might be acceptable, the Pro-life Movement increased its efforts to pass more restrictive state legislation. In 1992 the Supreme Court heard a challenge to the Pennsylvania law which included compulsory anti-abortion lectures by doctors, a twenty-four hour waiting period, a reporting requirement, spousal notification, and parental consent in *Planned Parenthood of Southern Pennsylvania v. Casey* [505 US 833]. In *Casey* the majority opinion upheld most of the abortion restrictions, articulating a new standard whereby state-based restrictions on abortion would be found constitutional if they did not represent an" undue burden" on women. No definition of undue burden was provided.

In the mid 1980s some opponents of abortion began to take direct action against abortion providers. The most written about group of the direct action wing of the Pro-life Movement is Operation Rescue. Breaking with the focus on simply limiting the legality

of abortion, Operation Rescue sought to stop the actual provision of services. Initial tactics included blockading entrances to abortion clinics. These sit-ins were billed as "non-violent" and often referenced the work of civil rights activists. Operation Rescue's most successful action occurred in 1991 with what would be called the "Summer of Mercy" in which Wichita Kansas was under siege for forty-two days as thousands of pro-life protesters converged on the city to blockade its clinics. A federal judge eventually issued an injunction ordering Operation Rescue to call off its demonstrations.

Although Operation Rescue claimed to be non-violent, harassment, bombings, arson, vandalism, invasions, and picketing became routine tactics of direct action activists. Blanchard (1994) argues that the adoption of violence as a tactic was fueled by feelings of alienation from the agenda of the more mainstream Pro-life Movement which had begun to focus its efforts to restrict abortion at the state level rather than to seek a full ban. The perceived failure of traditional lobbying tactics and executive regulation to bring about the level of change required to stop abortion led many in the movement to adopt a more aggressive and violent stance in order to stop abortion. The apex of violence was the actually killing of abortion providers.

In comparison to the Pro-life Movement, the Pro-choice Movement receives less scholastic attention. Staggenborg (1991), who studied the social movement organizations that comprise the Pro-choice Movement, provides the most comprehensive sociological discussion to date. According to Staggenborg (1991) no demobilization of the abortion repeal movement occurred after the passage of *Roe*. Rather the growing strength of the countermovement required the institutionalization of the Pro-choice Movement and the

use of tactics geared at maintaining abortion legality through legislative and judicial processes.

Although the Pro-life Movement had successfully elected Reagan as president there remained insufficient support for the pro-life agenda in Congress. Despite numerous attempts, the Pro-life Movement failed to pass a constitutional amendment banning abortion. These attempts, however, raised concern about the right to abortion among the pro-choice public. The Pro-choice Movement was additionally concerned with the ability of the countermovement to forward its agenda by changing the composition of the courts. In 1987 open warfare broke out over the nomination of Robert Bork for the Supreme Court. The pro-choice movement galvanized opposition, eventually defeating Bork, resulting in the appointment of an abortion-rights moderate who, while not willing to overturn *Roe,* accepted new restrictions on abortion in the *Webster* decision.

The Pro-choice Movement experienced its greatest successes in the early 1990s. As the Court heard *Casey* in 1991, the Pro-choice Movement sponsored the March for Women's Lives, drawing between 500,000 and 700,000 marchers to Washington DC. The momentum of the Pro-choice Movement culminated with the election of President Bill Clinton in 1992. Just two days after his inauguration, President Clinton issued several executive orders overturning five abortion restrictions put in place by the prior Reagan/Bush administrations. During his term he appointed two pro-choice judges to the Supreme Court. In March 1993 Dr. David Gunn was shot and killed, shocking the nation and prompting a call for federal legislation to protect women from clinic violence. As the Freedom of Access to Clinic Entrances Act (FACE) was being debated in Congress, two

additional physicians were shot (one wounded and one killed). These killings prompted the quick approval of the federal FACE legislation.

Like the Pro-life Movement, however, the Pro-Choice movement lacked the votes to pass national legislation to codify in law their position on legal abortion. Efforts instead focused on challenging state laws to restrict access to abortion. No large national efforts of the Pro-Choice movement were undertaken until the legal right to abortion was again threatened by the election of a pro-life president, George W. Bush. In 2004, a repeat of the March for Women's Lives drew over 1,000,000 abortion rights supporters to Washington D.C. Despite this showing a majority pro-life Senate was elected along with the reelection of President G.W. Bush. Although the Pro-choice movement has sought to galvanize grassroots support for its cause, two new Pro-life Supreme Court justices received confirmation in 2005 and 2006.

Saletan (2003) examines the overall successes and failures of the Pro-choice Movement strategy in his work on how conservatives allegedly "won the abortion war." His particular interest is the adoption by the Pro-choice Movement of the "who decides" frame—a frame in which support is sought not for abortion rights but for keeping the government out of the decision. (See Condit (1990) for a more detailed discussion of how discursive formations are used to forward a particularized understanding of abortion and Petchesky (1987) for a discussion of how the fetus has been used.) Saletan argues that while the "who decides" frame is successful in maintaining abortion as legal, it fails to gain actual support for abortion rights as women's rights. With a few exceptions, most observers of social movement activity and abortion have failed to deal with issues of race. In her work on the subject, Nelson (2003) helps connect the reproductive rights

movement with resistance to the eugenics movement and efforts to address sterilization abuse.

In addition to studying the political histories of the movements, sociology is interested in the people that actively join the two movements and in particular the meaning of abortion to those activists. The first major study in this arena was Luker's (1984) landmark work on activists in California. Luker found that differing views of motherhood explained women's engagement in abortion social movements. For those on the pro-life side, legal abortion was a referendum on the value of "stay at home" motherhood. Ginsburg's (1989) study of the battle over the opening of an abortion clinic in Fargo, North Dakota reached a similar conclusion that those engaged in oppositional movements saw the meaning of abortion differently. Her work concludes that abortion is a symbolic focus for the assertion of mutually exclusive understandings about the place of women in society.

In her work on pro-life activists, Maxwell (2002) uses social movement theory to focus on the individualized meaning of abortion for pro-life activists; she argues that many activists view their efforts as fulfilling a personal obligation to God. Other women use activism as a means to resolve personal conflict with their own abortion experiences. Mason's (2002) work on the apocalyptic narrative of pro-life politics seeks to locate the extremist position which justifies "killing in the name of life" within the Pro-Life Movement as part of a larger effort to reestablish the United States as a Christian nation.

The rapid decline in the number of abortion providers in the United States requires a renewed attention to the role of abortion within U.S. medicine. In addition to driving some physicians away from providing abortion care, the rise in violence is

understood to have prompted the activation of a new pro-choice physician counter-counter movement. The creation of the organization Medical Students for Choice is seen as a turning point in the reengagement of physicians as a social movement player in the current fight over abortion. The uneasy alliance between physician-led activism and feminist-led activism, which historically was critical of physician power and dominance, is discussed by Joffe, Weitz, and Stacey (2004). Another development within medicine that receives some attention is the twelve year political battle over the approval by the U.S. FDA of mifepristone, known as RU 486 in France and most commonly as the "abortion pill." Although widely adopted by the health care providers already offering abortion services, medication abortion is not routinely offered by regular physicians as originally projected when RU486 was thought to be a solution to the "abortion war."

While the debate regarding abortion in the United States is not mirrored throughout the world, a growing globalization of the Pro-life/Pro-choice struggle is underway. This tension was played out at both the International Conference on Population and Development in Cairo in 1994, and the Fourth World Conference on Women held in Beijing in 1995, where disagreements regarding abortion dominated many efforts to build an international agenda. Opposition to international recognition of abortion rights was initially raised by a small group of countries (some Muslim, some Catholic, including the Vatican delegation) but is now led by the U.S. In 2000 newly elected President George W. Bush re-imposed the "global gag rule," a measure which stipulates that no U.S. foreign aid funds for family planning services could go to organizations which use their own funds for abortion services or referrals. This ban also precludes organizations that wish to receive US funds from engaging in advocacy related

to abortion, thereby silencing many pro-choice voices within developing nations. Delegations from the U.S. to recent international convenings have mandated that opposition to abortion be a central component of any agreement to which the U.S. would take part. Within many developing nations as well as former republics of the Soviet Unions, anti-abortion efforts are receiving substantial financial support from U.S.-based Pro-life Movement organizations (see Kulczycki, 1999 for case examples).

Within other developed nations little attention has been paid to the existence or non-existence of abortion social movements, in part due to the lack of extreme polarization within electorates and the absence of violence. Francome (2004) briefly discusses the existence of abortion social movements within the U.K. and Ferree et al (2002) expose those groups working within Germany.

See Also: Women's Movements; Gender and Social Movements; Abortion as a Social Problem; Family Planning, Abortion, and Reproductive Health; Women's Health; 1st, 2nd, 3rd Wave Feminism; Marriage, Sex and Childbirth

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[In Harvard style in accordance with publisher's guidelines. Maximum 20 references.]

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Section III: The Introduction of Medication Abortion

CHAPTER 9: PUBLISHED ARTICLE

"'MEDICAL' AND 'SURGICAL' ABORTION: RETHINKING THE MODIFIERS"

Weitz, T. A., Foster, A., Ellertson, C., Grossman, D., & Stewart, F. H.

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Short communication

"Medical" and "surgical" abortion: rethinking the modifiers

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1. Introduction

When the mifepristone/misoprostol abortion regimen was introduced, those working to advance the method were charged with creating language to describe the new option. The goal was to develop language that was understandable and acceptable to healthcare providers as well as the general public. Despite work to this end, the struggle to find clear, accurate and accessible language continues.

Two descriptors, "medical" and "surgical," have become the most commonly used modifiers for abortion. While these modifiers are comprehensible to most professionals active in the abortion field, the phrases "medical abortion" and "surgical abortion" are confusing for health service providers outside the abortion field, policymakers and the public. As the current debate over so-called "partial-birth abortion" has demonstrated, the impact of language on provision of services, policy and public perception is significant. We believe it is time to rethink these modifiers and take on the challenge of redefining our language. This editorial both reviews the limitations of the current lexicon and proposes alternative modifiers that are clearer and more precise.

2. Limitations of the phrase "medical abortion"

Nonaspiration abortion, that is, abortion brought about by an agent administered orally or by injection, is commonly referred to as "medical abortion." Despite vigorous efforts to promote awareness among health providers, policymakers and the public, the term "medical abortion" remains confusing. In popular use, the term "medical" is often associated with medical necessity and with physician-based practices. To those outside the abortion field, all abortions are "medical," except for those performed illegally and/or unsafely by untrained practitioners. Also, use of the term "medical" to mean drug administration is inconsistent with common uses of the term in other areas of health care; "medical record" is not limited to the use of medications, "medical jurisprudence" is not confined to pharmaceutical questions in criminal and civil law and "medical devices" generally refer to nonmetabolized interventions and aids. If "medical" actually means only the use of a pharmacological agent, the commonly understood term "medical procedure" would make no sense. Rather, medical procedures typically mean procedures in the field of health broadly, or procedures undertaken by health service professionals.

The phrase "medical abortion" was selected after significant thought and consideration. An appeal to rethink the modifier is not a critique of this early and important work. Rather, it is an acknowledgment that healthcare professionals, policymakers and the public have found this terminology confusing and, therefore, that revisiting the terminology is warranted. Clients who present for the procedure often request "the abortion pill" or "RU-something," suggesting that women will invent their own vocabulary if ours is puzzling. A number of alternative phrases have been proposed, including "abortion pills," "miscarriage pills," "pharmaceutical abortion" and "medicinal abortion." All of these phrases have merits, but all have been criticized for their linguistic deficiencies; the word "pill" excludes liquids, whether delivered orally or by injection, and is easily confused with oral contraceptive pills; "pharmaceutical" has corporate connotations and "medicinal" is often associated with alternative, complementary or herbal therapies.

While all of these alternative phrases may perhaps be preferable to the phrase "medical abortion," we suggest that "medication abortion" most accurately represents use of the family of safe and effective drug-based methods that can terminate an unwanted pregnancy. Defined by the *Oxford*

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English Dictionary as "the action of treating medically; treatment with a medicinal substance" [1], the modifier "medication" clarifies the type of abortion and remains consistent with the broader lexicon. Further, the phrase "medication abortion" is consistent with the terms used in other languages, and a clear, accurate, accessible phrase in English has the potential to complement and influence the development of appropriate terms in other languages.

2. Limitations of the phrase "surgical abortion"

The term "surgery" is defined by *Stedman's Medical Dictionary* as "the branch of medicine concerned with the treatment of disease, injury, and deformity by physical operation or manipulation" [2]. Within the context and history of the health sciences as well as in general understanding, surgery implies incision, excision and suturing and is associated with the physician subpopulation of surgeons. Surgery also evokes images of green gowns, operating and recovery rooms and anesthesia. When used narrowly in the context of abortion, "surgical" currently encompasses a heterogeneous grouping of procedures and interventions. The use of the term "surgical" as a descriptor for all nonmedication abortions obfuscates the differences in the procedures and the training requirements for provision, as well as evokes scary imagery that contributes to wider misunderstanding.

First-trimester abortion interventions are most often completed through either electric or manual vacuum aspiration. Aspiration abortions are typically simple procedures that can safely be undertaken in a regular exam room, with local or oral analgesics and with little or no "recovery" time afterwards. These procedures are consistent with the scope of practice of most primary care physicians (nonsurgeons) and advance practice clinicians who serve women of reproductive age. Use of the term "surgical" to describe first-trimester aspiration abortions distances abortion procedures from other routine and common gynecological procedures. For example, IUD insertions and endometrial biopsies are not considered "surgery," despite employing similar techniques to stabilize the cervix with a tenaculum in order to enter the uterus through the cervical os, often after minor dilation. In this way, the phrase "aspiration abortion" more accurately reflects the family of first-trimester abortion procedures commonly performed.

Certainly, there are types of abortion aptly described as "surgical." A laparoscopic intervention to terminate an ectopic pregnancy, a hysterotomy or a hysterectomy performed to save the life of a pregnant woman are procedures that are consistent with the term "surgical abortion." Such abortions are complex, the providers require surgical training, and adherence to regulations and standards associated with other surgeries are appropriate. Furthermore, such abortions are consistent with more general public perceptions of what undergoing "surgery" means. In this limited context, the phrase "surgical abortion" appears warranted.

3. What's in a name?

More than an issue of semantics, the terminology used to describe abortion procedures influences political, legislative and medical institutions. The recent attention given to so-called "partial birth abortion" highlights the ability of language to alter public perception and change public policy. This ambiguous and misleading term, which has been used to describe a number of distinct procedures, including dilation and extraction and dilation and evacuation, has significantly shaped public debate, federal legislation and media coverage. Those concerned with abortion access should learn from this experience. It is time to rethink the language of first-trimester pregnancy termination with the goal of minimizing the potential for imprecision, confusion and intentional distortion. We propose the modifiers "medication" and "aspiration" as a more accurate lexicon for abortion interventions.

Transforming language is never easy and requires commitment on the part of those who have become familiar with and regularly use the old terms. Changing language also grows more costly as a body of written and indexed literature accumulates in a field. We urge leaders in the field of reproductive health to rethink the current modifiers and to adopt and promote new, more precise terminology. Including "medication abortion" and "aspiration abortion" as keywords, using the new modifiers in indices, and integrating the phrases into oral presentations and patient materials represent a few of the concrete steps possible to make abortion terminology serve women better.

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CHAPTER 10: PUBLISHED ARTICLE

NORMALIZING THE EXCEPTIONAL: INCORPORATING THE "ABORTION PILL" INTO MAINSTREAM MEDICINE

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Normalizing the exceptional: incorporating the "abortion pill" into mainstream medicine

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Abstract

Mifepristone, also known as RU-486, and in the US known as "the French abortion pill", finally received FDA approval in the United States in September 2000. This paper discusses the steps now in process to integrate this drug into mainstream healthcare and the sociological implications of those efforts. Each of the steps that is normally taken to introduce a newly approved medication in the US context is rendered highly complex in the case of mifepristone—because of the unique circumstances of abortion in both American culture generally, and medical culture specifically. The story of RU-486/mifepristone, as it is currently unfolding, can be understood as one of attempting to "normalize the exceptional". After offering a brief historical overview of the protracted struggle for FDA approval of mifepristone in the US, this paper discusses the typical processes for integration of a newly approved medication into mainstream medicine and contrasts this process with the special challenges posed by a drug that is associated with abortion. We outline the challenges to implementation, including both external and internal obstacles. We compare the traditional role of a pharmaceutical company in drug diffusion and the circumstances of the company that produces mifepristone in the US. We discuss such external obstacles as the conflict between the FDA-approved regime and an evidence-based alternative; the necessity for physicians to order and dispense this drug; the ambiguity over the need for ultrasonography; and insurance reimbursement, malpractice, and other legal issues. Internal issues addressed include "turf issues" between medical specialties and between physicians and advanced practice clinicians as well as concerns over "cowboy medicine", and patient compliance. This paper concludes with an exploration of the sociological implications of this effort to "normalize the exceptional".

Keywords: Abortion; Mifepristone; Technological diffusion; United States

Introduction

Mifepristone, also known as RU-486, and in the US known as "the French abortion pill", finally received US Food and Drug Administration (FDA) approval in the United States in September 2000. This paper discusses the steps now in process to integrate this drug into mainstream healthcare. Each of the steps that is normally taken to introduce a newly approved medication in the US context is rendered highly complex in the case of mifepristone—because of the unique circumstances of abortion in both American culture generally, and medical culture specifically.

The story of RU-486/mifepristone, as it is currently unfolding, can be understood as one of attempting to "normalize the exceptional". Abortion is widely acknowledged as the most divisive of all social issues in American society (see Beckman & Harvey, 1998; Luker, 1984; Petchesky, 1984; Rubin, 1994; Solinger, 1998). To list just some indicators of this exceptional status: seven

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members of the abortion providing community have been murdered and thousands of others terrorized at their workplaces (NARAL, 2001); and abortion provision receives more legislative scrutiny than any other branch of medicine,[1] as evidenced by the ongoing high profile Congressional battle over so-called "partial birth abortions", the involvement of Congress in standards for abortion training in residency,[2] and, as we discuss below, the fortunes of mifepristone itself being inextricably connected to presidential politics.

Abortion furthermore, is also highly contested *within* medical culture as well. The training in abortion in obstetrics and gynecology residency programs has long been inadequate, with very few residencies routinely providing such training for first-trimester abortions, and even fewer for second-trimester procedures.[3] The well-documented shortage of surgical abortion providers—estimated at about 2000 in the US (Henshaw, 1998)—is only expected to get worse as the current generation—disproportionately in their 50s and older—heads toward retirement (Grimes, 1992). And of course, there is the often-repeated fact of only 14% of US countries having an abortion provider (Henshaw, 1998). There are active "pro-life" caucuses within the American College of Obstetricians and Gynecologists (ACOG) (American Association of Pro-Life Obstetricians and Gynecologists, 2001) and in other medical organizations as well (National Pro-Life/Pro-Family Organizations, 2001). The recent spate of hospital mergers, with many community hospitals joining with Catholic-controlled health care systems has reduced the prospects of hospital-based abortions which now constitute only an estimated 7% of all abortions in the US (Henshaw, 1998).

But perhaps the most fundamental challenge to the "normalization" of mifepristone is the longstanding stigma of abortion provision within US medical circles—even among the overwhelming majority of physicians who consider themselves "pro-choice" (Joffe, 1995). As one of us has documented at length elsewhere, since the *Roe v Wade* decision in 1973, abortion provision has been marginalized from mainstream medicine. The majority of abortions now take place in freestanding clinics, and most American physicians having little direct experience with abortion services (Joffe, 1995).

After offering a brief historical overview of the protracted struggle for FDA approval of mifepristone in the US, this paper will discuss the typical processes for integration of a newly approved medication into mainstream medicine and contrast this process with the special challenges posed by a drug that is associated with abortion. The materials on which this paper has drawn were collected as part of a larger ongoing project by the two authors who are tracking the spread of mifepristone, and include observations made at professional meetings at which this drug has been discussed; interviews with key individuals involved with training and setting protocols in the use of mifepristone; health care providers who have used the drug, and other figures in the medical world with an interest in the dissemination of mifepristone; and examination of numerous documents pertaining to the medication.

Historical background

Mifepristone, then known as "RU-486", was discovered by a team of French scientists, led by Etienne Balieu, and became available to French women in 1988. Mifepristone is an antiprogestin, which alters the uterine lining and disrupts attachment of a fertilized egg; it is used in combination with another drug, a prostaglandin, which causes the uterus to contract and expel the products of conception (Stewart, Wells, Flinn, & Weitz, 2001). In short, if used early in pregnancy (from 7–9 weeks gestation), this drug regime promised to offer women a non-surgical means of terminating a pregnancy.

The pill immediately became entangled in international antiabortion politics—including visits to France by both abortion proponents and opponents from the

[1] In the last 6 years, state legislatures have enacted 264 anti-choice measures. In 2000, 435 antichoice legislative measures were considered by state legislatures; a total of 45 measures were enacted by 23 states during this time. These regulations fall into several broad categories: attacks on minor's rights, funding for "fake clinics", fetal protection legislation, funding limitations, informed consent and waiting period requirements, medical abortion legislation, conscience clause legislation, bans on abortion procedures, and care delivery regulations (NARAL, 2001).

[2] In 1995, after extensive consultation within the medical profession, the American Council of Graduate Medical Education approved new standards for obstetrics and gynecology residencies requiring training in abortion and the management of abortion complications. The strength of these requirements was severely mitigated when, in an unprecedented move, Congress stepped in and passed a law prohibiting such training requirements (Hodgson, 1998).

[3] According to a 1991–1992 survey of program directors of obstetrics and gynecology residency programs, only 12% of programs provide routine training in first-trimester and 7% in second-trimester abortion (MacKay & MacKay, 1995). A study conducted in 1998 by the National Abortion Federation of residency programs in obstetrics and gynecology found that 46% of programs routinely offered first-trimester training and 29% offered second-trimester training (Almeling, Tews, & Dudley, 2000). The authors, however, urge caution on interpreting these results because of the low return rate. See also Landy and Steinauer (2001) for a discussion of the authors' failure to define "routine".

United States, with the latter threatening boycotts of the manufacturer's other products if the pill were to become available in the US (Ulmann, 2000). Both sides of the abortion debate perceived the stakes surrounding mifepristone to be very high in the US context because of the pill's potential to expand access to abortion. "Performing an abortion" would no longer have to depend on surgical training, and in theory, any clinician with prescription writing privileges could become an abortion provider. Furthermore, abortions could move more easily into settings other than freestanding clinics, and thus bypass the violence that had become so commonplace by the end of the 1980s. As the Feminist Majority enthusiastically (and in retrospect, quite naively) proclaimed on its website (in a statement since withdrawn from the site), once mifepristone was approved by the FDA for use in the US, "the number of abortion providers could double overnight" (The Feminist Majority Foundation, 1996).

During the presidency of George Bush Sr., an import ban was imposed on mifepristone, except for a few research projects. When Bill Clinton came to office in 1993, he lifted the import ban, and furthermore convinced Roussel Uclef, the French company holding the patent to this drug to transfer US rights to the drug to the Population Council, a non-profit research and advocacy group in New York City (Ulmann, 2000). The Population Council sponsored trials of mifepristone in the US, and additional trials were conducted by a small abortion rights group called Abortion Rights Mobilization (Hilts, 1996).

The FDA gave tentative approval to mifepristone in September 1996, essentially expressing satisfaction with the efficacy and safety of the drug. The remaining steps to approval centered around "manufacturing and labeling issues" (Talbot, 1999). The 4-year gap between "tentative" and "final approval" of this drug offers a very powerful illustration of the thesis of this paper—the difficulties in "normalizing the exceptional". No major pharmaceutical firm stepped forward and sought the commercial rights to offer this drug. Thus, the Population Council, which held the patent, was forced into a series of negotiations, some disastrous, with various would-be manufacturers and distributors (Talbot, 1999). It was commonly understood that the reluctance of regular drug companies to take on this drug stemmed from fears of antiabortion boycotts, and very possibly, violence (Lader, 1995). Finally, the issue of the manufacturer was resolved with the formation of Danco, a small company set up with the sole purpose of producing and marketing mifepristone (Talbot, 1999). The security issues surrounding this enterprise are so great that Danco operates out of an office with an unlisted phone, and with the name of another company on its door.

Yet another problem that delayed final FDA approval was the clash between the agency's traditional expectations of openness with respect to location of the plant where drugs are manufactured, and the need for secrecy on the part of Danco, given the very real threats of antiabortion terrorism (Kaufman, 2000). When the FDA finally did announce approval of the sale of RU-486, it took the unprecedented stop of refusing to disclose the name or location of the manufacturer, citing concerns about employee safety and security (Pan, 2000). Thus, we see how the unique politics of abortion—not any inherent questions about the efficacy of the drug—brought a 4-year delay to the drug's approval (and along the way, became one of the defining issues for confirmation of the heads of the FDA during both the Clinton and, currently, the Bush Jr. presidencies).

As noted, final FDA approval of mifepristone occurred in September 2000. That previous June, word had "leaked" to the pro-choice community that the FDA was close to giving final approval of the drug—but with some onerous restrictions (Zimmerman & Lueck, 2000). The most worrisome of these, from an abortion rights perspective, was the stipulation that only those already trained in surgical abortion could offer mifepristone. The ostensible justification for such a restriction was that some 4–5% of mifepristone patients would need surgical backup services, either for a failed abortion, or because of some retained products of conception. This possibility was deeply disconcerting to the abortion rights movement because if the drug were to be made available only to those who already provided surgical abortion, one of the greatest promises of the drug—to bring in new providers—would be negated.

When final FDA approval was announced in September 2000, the above-mentioned restriction was modified to allow non-surgical providers to offer mifepristone as long as they had made back-up arrangements with a surgical provider and would testify to this in writing. The approval also stipulated that the drug could be used up to 49 days of pregnancy, that the provider had to have the ability to "assess the duration of a pregnancy accurately", and to diagnose ectopic pregnancies. Furthermore, in a step highly unusual for the FDA, each physician wishing to use mifepristone had to sign a "provider's agreement" stating that he/she met the above requirements. The provider's agreement also stipulates that he/she will report to Danco all adverse events—"hospitalization, transfusion, or other serious events"—that occur with any patients (Danco Laboratories, 2000a). Equally unusual, each patient that would receive the drug had to sign a detailed "patient agreement", in the physician's presence, consisting of 14 separate points about the protocols of the drug, the patient's certifying her understanding of the length of

her pregnancy and the specific timeframe for returning for care (Danco Laboratories, 2000b). Such FDA-mandated patient agreements are highly unusual, and are typically used in cases of drugs that are acknowledged to be highly dangerous, as with the recent reintroduction of Thalidomide into the US, for the treatment of leprosy (US Food and Drug Administration, 1998). What is unusual in this case is that the FDA had already approved mifepristone as safe some 4 years prior. The FDA issues of concern at this time regarded manufacturing and not drug safety. A final unusual aspect of the agreement worked out between FDA and Danco was that unlike the vast majority of other FDA-approved medications, this drug would not be available in pharmacies via a prescription—but rather each provider would order directly from the manufacturer.

The elation of the abortion rights movement over the long sought FDA approval of mifepristone in Fall (2000) was shortened, a few months later, by the Supreme Court's resolving of the contested presidential election in favor of George W. Bush Jr. During the campaign Bush Jr. had studiously avoided comment on mifepristone, but the pro-choice movement was alarmed when during the confirmation hearings of Tommy Thompson, Bush's nominee to head the Department of Health and Human Services, Thompson stated that he might call for a "review" of the mifepristone approval (Pear, 2001). Since then, the Secretary has backed away from that statement, but almost immediately after the FDA's action, two antiabortion congressmen introduced legislation that would implement the previously proposed FDA restriction confining mifepristone use to surgical abortion providers who are also certified in ultrasound use (S 251/HR482—Patient Health and Safety Act). As of this writing, in Spring, 2002, the fate of this legislation remains unclear.

"Normal" processes of diffusion/adoption of innovation

Once the FDA approves a drug, the process for diffusion into mainstream medical care is strongly influenced by the activities of the drug's manufacturer and the health care system. With regard to the diffusion of mifepristone, the abortion issue complicates each of these routinizing processes.

The estimated cost of discovery or synthesis of a potential new drug molecule is between $100 and $500 million (Berkowitz & Katzung, 2001). DiMasi, Hansen, Grabowski, and Lasagna (1991) estimated that the average cost of bringing a new drug to the point of marketing approval was $231 million in $1987. Although this figure has been recently challenged in a report from the Public Citizen,[4] the necessity for high expenditures in order to market a new drug, remains unchallenged. With regard to mifepristone the question is less what it cost to develop the drug—since Danco acquired an already developed product—but rather what it will cost to introduce the drug to physicians. In general, the pharmaceutical industry's marketing efforts are directed at affecting doctors' prescribing habits through six means of drug promotion: detailing, sampling, direct mailing, journal advertising, general media advertising, and the sponsorship of continuing medical education (Schweitzer, 1997). Pharmaceutical sales representatives ("detailers") have traditionally been an important way of informing physicians about new products, answering questions and maintaining good will. In 1983, more than 55% of US drug company promotional budgets (about $115 million) was spent on all aspects of detailing (Schweitzer, 1997). This interaction between physicians and detailers often begins in medical school and continues through residency and in practice. The providing of free samples represents another 9% of total promotional expenditures (Schweitzer, 1997). Free samples are especially important for clinics serving low-income patients. A survey by Lichstein, Turner, and O'Brien (1992) found that pharmaceutical companies provided samples in 70% of the resident clinics and 35% of the residents depended on these samples "moderately" or "a lot". The rationale for the industry in providing samples is that a doctor must be acquainted with the drug in order to prescribe it with confidence. Direct mail claims another 4–6% of the promotional expenditures usually taking the form of free copies of controlled journals and direct advertising flyers from drug companies (Schweitzer, 1997). Medical journal advertising targeted at physicians and public media advertising targeted at patients represent two additional strategies for drug companies. Finally, the sponsoring of continuing medical education (CME) programs is utilized to inform providers of the availability and use for new drugs.

Once a drug has been introduced to physicians, the health care system then usually plays an active role in facilitating or prohibiting uptake. Cost containment is

[4] In 2001, The Public Citizen released a report "Rx R&D Myths: The Case Against the Drug Industry's R&D "Scare Card" challenging the claims that drug development was risky for the pharmaceutical industry (Public Citizen, 2001b). The report argues that the claims for high R&D costs are highly misleading and misunderstood extrapolations from DiMasi's 1991 study. The $500 million figure which drug companies often cite includes significant expenses that are tax deductible and unrealistic scenarios of risks. According to the Public Citizen Report, a simpler measure suggests that after-tax R&D costs ranged from $57 million to $71 million for the average new drug brought to market in the 1990s, including failures (Public Citizen, 2001a).

central to current decision-making by health care systems. Health plans and purchasers often make decisions about promoting the availability of new drugs based on whether it will save money over the alternative options. Cost-effectiveness and cost-benefit studies are usually undertaken to assess the potential of the new drug to reduce health care expenditures. These studies have historically been sponsored by the drug companies themselves, but recently scrutiny over the validity of these results has promoted the conducting of more independent research. Since the early 1990s the federal government has taken an active role in promoting research on both cost and quality of health care through the Agency for Healthcare Research and Quality (AHRQ) formerly the Agency for Health Care Policy and Research, AHCPR), which supports research designed to improve the outcomes and quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to effective services. In addition to conducting cost-related studies, the AHRQ also supports the development of evidence-based practice guidelines.

Possibility of "deskilling" is a third normal factor that facilitates the introduction of a new medication. As drugs are introduced into the health care marketplace that reduce the need for surgical intervention, the level of specialization of the physician is subsequently reduced. Again, concerns about cost containment often prompt the health care system to support the transfer of care management from the level of the specialist to the level of the generalist. For example, under managed care, primary care physicians receive financial incentives to reduce referrals to specialists and to manage patients within their practice. This process is particularly visible in the field of mental health where both pharmaceutical companies and health care systems are expending large resources to train primary care physicians in the medication management of women with depression. In addition to reducing the level of specialty among physicians, the process of medical care deskilling also routinely involves the devolution of care to non-physicians such as nurse practitioners and health educators. This is especially the case when the preponderance of the care involves counseling or education such as diabetes management and weight management.

Lastly the diffusion of the new drug involves the identification of new markets. Drug manufacturers and health care researcher collectively and separately seek to identify additional uses for the medication. As studies are completed, the drug is routinely used "off-label". This "off-label" use of an approved product for a purpose that is not included in its labeling is common and in accord with FDA guidelines if there is published evidence to support such use (Food and Drug Administration, 1982).

The challenges of implementation

None of these normal processes of diffusion cited above are present in a straightforward manner in the case of mifepristone. First and foremost Danco lacks the financial resources of other pharmaceutical companies since it only makes and distributes mifepristone. As such, it does not have a sales force that can actively engage in detailing nor the funds for large-scale advertising efforts. Sampling is also financially unaffordable for the company since a single packet of three tablets represents an approximately $600 investment on the part of the company. Also since mifepristone, as noted earlier, must be used in combination with another drug, a prostaglandin (in the United States, the drug misoprostol), the provision of samples of mifepristone is inadequate. Finally, because the drug cannot be dispensed to physicians until they have read and signed the providers' agreement the provision of samples is even more complicated. Direct mail and medical journal advertising are not without controversy. There is a fine-line between advertising of the drug and what is perceived as the advertisement of abortion, which is viewed by many as inappropriate. Direct-to-consumer advertising has been undertaken by the National Abortion Federation that has received foundation funding to buy advertising space in major women's journals. This effort has already been challenged in the courts by antiabortion forces (Duin, 2001). Danco has provided funds to support some limited CME activities but they are inadequate to reach a large number of providers and have, to date, been targeted predominately at current providers of surgical abortion.

Rather than visits and gifts from drug representatives and pressure from health care systems to implement cheaper alternatives, the leaders within the pro-choice medical community who are attempting to mainstream this medication, and the on-the-ground physicians who are considering incorporating this medication into their clinical practices, are operating in a unique environment in which the larger politics of abortion constantly hovers above all medical transactions. Put another way, not only are the normal processes of diffusion not readily available, for those who wish to promote this drug, a different—and quite unwelcome—set of factors are present—namely, the scrutiny of antiabortion legislators, lawyers, and activists. In this highly politicized context, the following are some of the challenges to the routinization of this drug within medical practice in the US that we noted in the immediate aftermath of the September 2000 FDA action.

External obstacles

The dosage

One of the first dilemmas to present itself was adherence to the FDA-approved protocol which was

developed by the FDA as a result of the original US trials, run by the Population Council in the mid-1990s. This protocol calls for the administration of 600 mg of mifepristone in the physician office followed by the administration of 400 mcg of misoprostol to be taken orally, in the physician's office, on day three of the procedure. In the years since the original Population Council trials (which ended in 1996) other trials—notably the ARM trials, headquartered at the University of Rochester—had shown essentially the same level of success with only 200 mg of the medication (Ashok, Penney, Flett, & Templeton, 1998; Schaff et al., 1999; Schaff & Fielding, 2000; Schaff, Fielding, Eisinger, Stadalius, & Fuller, 2000a; World Health Organisation Task Force on Post-ovulatory Methods of Fertility Regulation, 2000). Like other health care expenditures, the incentive for both the physician and the payer is to promote the use of the lower dosage. This drug, however, is unlike other drugs and has a preprinted patient agreement that delineates the approved FDA protocol for use. Additionally, unlike other medications, the scrutiny over the provision of abortion caused consternation among many potential providers. Why charge patients for more drugs than they need and why have patients ingest more drugs than they need? Some providers, mindful of the special scrutiny usage of this drug would bring, are hesitant to depart from the original FDA protocol despite the traditional practice of widespread "off-label" use of medications in the field of medicine. Others are engaging in the unusual practice of having the patient sign two consent agreements: the one from Danco and one that indicates that the medication regime to be followed differs from the one indicated in the other signed consent.

In yet another departure from the FDA protocol, many providers also expressed preference for a variation of the administration of misoprostal, the second drug in the mifepristone regime. The original Population Council protocol called for 400 mcg of misoprostol to be taken orally, in the physician's office, on day three of the procedure. The subsequent ARM trials found equal effectiveness with 800 mcg of misoprostol administered vaginally by the patient at home, from 24–72 h after the mifepristone was taken (Schaff et al., 1999; Schaff et al., 2000a; Schaff et al., 2000b; Schaff, Stadalius, Eisinger, & Franks, 1997). This latter protocol is far preferable to many providers because of the inevitable disruptions to office routines—especially the demand on bathrooms—caused by women in the midst of miscarrying. It is obviously preferred by many patients as well who prefer to complete the procedure in the privacy and comfort of their own homes (Elul, Pearlman, Sorhaindo, Simonds, & Westhoff, 2000; Joffe, 1999; Schaff et al., 1999).

The use of this second medication was further politicized when in September 2000 the manufacturer of misoprostal issued a letter explicitly denouncing its use in medical abortion[5] (Cullen, 2000). As a response to that letter, ACOG sent a letter to the FDA in October 2000 stating its support for the use of misoprostol in early abortion in combination with mifepristone (ACOG, 2000).

As of Fall (2001), the majority of training and research groups and many individual practitioners appeared to be comfortable with the "evidence-based" usage of 200 mg mifepristone and home-administered 800 mcg vaginal misoprostol (National Abortion Federation, 2001; Stewart et al, 2001), citing the widespread practice of "evidence-based usage" of medications elsewhere in medicine.[6] But for the more cautious, we can speculate, departure from the original protocol is a worrisome matter, given the highly scrutinized environment in which abortion provision takes place. There remains the unresolved question of legal liability should a patient have a negative health outcome from her use of either medication. Antiabortion opponents have sought to capitalize on the change in abortion regime claiming that providers are implementing the new regime in order to make more money and compromise patient safety (see National Right to Life Committee, 2001b).

Ordering requirements

As mentioned above, unlike most medications approved for use in the United States, under the agreement reach by the FDA and Danco, mifepristone is not to be available in pharmacies, where patients can go with a prescription. Rather, the drug must be ordered directly from the manufacturer by the physician, and both physician and patient must sign agreements pertaining to its use. For those already established in abortion services—i.e. freestanding clinics or individual physician offices that offered surgical abortions—this has not proved overly burdensome. But for potential new providers of abortion services, for example, faculty in hospital-based residency programs, negotiating the intricacies of this requirement with hospital-based pharmacies can be frustrating and time consuming.

[5] Misoprostol, most commonly known under the trade name, Cytocec, received initial FDA approval some time ago as an ulcer drug, but besides its "off-label" use in medical abortion, it has also been widely used in a range of obstetrical practices, which helps account for ACOG's prompt response to the Searle action. G.D. Searle and Company was the pharmaceutical unit of Monsanto company which joined with Pharmacia and Upjohn on April 3, 2000 to create the Pharmacia Corporation (Pharmacia Corporation, 2001). Since the dissemination of the "Searle letter", Pharmacia Corporation has made no further attempts to limit access to misoprostol.

[6] Where there is substantial research and scientific evidence to support a particular "off label" use of a medication, the term "evidence-based" is used to designate the regimen.

Likewise, because many health care systems are engaged in large-scale drug purchasing arrangements, physicians within these systems may not have the ability to order medications directly from Danco, as is required. And this unusual requirement can also be off-putting for private practice physicians contemplating merely a handful of medical abortions a year, and reluctant to purchase the drug in advance, and "to have that stuff just expiring in your closet", as one medical physician activist speculated to us. It is still too early to tell whether this unusual ordering procedure will in itself be a widespread disincentive for the use of mifepristone.

Use of ultrasound

Whether or not to use ultrasound is a third perplexing issue as the first generation of mifepristone users get underway. In fact, nearly all of the veteran surgical providers who are incorporating this drug into their practices do routinely use ultrasound—as by now, most routinely use this in surgical abortion (Joffe, 1999). The question is, "Is it necessary?" This question is possibly quite relevant for the spread of this regime to new providers. Family practice physicians, for example, who are seen as among the biggest potential 'new' providers, very often do not own such machines—which can cost from about approximately $12,000 to almost $100,000 depending on the model. Among the first generation of mifepristone "pioneers", i.e. those who participated in the US trials and helped establish the first protocols for various pro-choice medical groups, there was lively debate on this topic, and the decision was ultimately made to recommend, but not require, use of ultrasound (National Abortion Federation, 2001; Stewart et al., 2001). The FDA approval in September 2000 did not require use of ultrasound. Those arguing against the absolute requirement of ultrasound pointed to the fact that in France, where mifepristone was developed and first used, this technology is not routinely used, and that other reliable methods—most notably, a pelvic exam and a patient's medical history—exist for reliable dating of early pregnancies (Ellertson et al., 2000). Serial βHCG blood tests can be used in exchange for ultrasounds to follow potential medication failures or ectopic pregnancies.

To be sure, various arrangements are available to potential mifepristone users in differing situations. Those in a group practice may be able to send a patient for an ultrasound to a colleague who does have this technology. Various efforts are underway by pro-choice medical groups, such as National Abortion Federation and Planned Parenthood, to expand training in ultrasound for potential providers of mifepristone. Group purchasing agreements will be increasingly available and the price of ultrasounds is expected to reduce over time. Nevertheless, for some potential providers, the perception that ultrasound should be routinely used for medical abortion may be a disincentive to proceed, if this technology is not readily available. Again, we can point to the special scrutiny that abortion care typically receives to understand provider reluctance to depart from commonly used protocols, even if not formally required.

Insurance reimbursement and malpractice coverage

Resolving issues of insurance reimbursement and malpractice coverage are among the most consequential aspects of the normalization of mifepristone into medical circles. Very gradually in early 2001, commercial insurance companies began to establish guidelines in this area. Most commercial insurers announced they would treat medical abortion similar to surgical abortion. Thus, for those individuals or facilities already offering surgical abortion, reimbursement has not been that problematic. For new providers, however, the situation was more problematic, and often involved negotiating new terrains they had not previously entered (Joffe, 2000).

Medicaid, in state programs that reimbursed for surgical abortion, has also began slowly to issue guidelines. This has in some cases proved extremely difficult, as the stringent policies established for surgical abortion often did not make sense for the medical abortion regime, for example, requirements governing width of aisles, number of sinks in the operating suite and so on.

The issue of malpractice coverage for new providers remains at this point an even more challenging issue. Those contemplating adding mifepristone to their services, especially in a private or group practice situation, typically face considerably higher malpractice rates. (The situation is usually much easier for those who work in hospital-based clinics or community-based clinics, and thus are covered under the institutions' policies—unless of course, such policies specifically prohibit abortion coverage, as is the case in some publically funded facilities). In the long run, the most likely solution to this problem may be group malpractice policies worked out by such organizations as the National Abortion Federation or other pro-choice medical advocacy groups. In the short run, however, malpractice may prove a significant stumbling block to commencing mifepristone provision on the part of those who are otherwise prepared to do so.

Legal issues

Similarly, it is of enormous consequence as to how the legal issues that presently govern surgical abortion in various states will be applied to medical abortion. Among the most outstanding of these issues: parental notification and consent laws; 24–48 h waiting periods; reporting requirements; physician only laws; and laws governing treatment of fetal tissue.

Generally speaking, legal experts have concluded that "medical abortion will...be regulated in much the same way as surgical abortion", especially with respect to parental involvement and mandated waiting periods (Borgmann & Jones, 2000). However, in a number of specific cases of legal regulations, the quite different nature of the two abortion modalities may give medical abortion providers grounds for successful appeal of these laws. For example, so-called TRAP laws ("targeted regulations of abortion providers") exist in a number of states and consist of detailed, often burdensome requirements covering, among other things, the physical facilities in which abortions may take place, regardless of the nature of the abortion procedure. As the authors of a key statement on legal aspects of medical abortion put it, "these restrictions...are particularly irrational when applied to medical abortion...it is non-sensical to require recovery rooms with 4 beds or a minimum square footage for operating room" (Borgmann & Jones, 2000). Similarly, some state laws governing fetal tissue examination are notoriously difficult to implement—if not absurd—when applied to medical abortion; some states' laws, for example, require physician examination of fetal tissue. While comprehensible for surgical abortions, in the case of medical abortion, such laws would either require that patients' remain in the facility to expel the tissue, or, after expelling the tissue at home, i.e. undergoing the induced miscarriage, bring back the tissue to their doctors' offices (Kolata, 2000).

Finally, "physician only laws" which now apply in most states (only in Montana, Vermont and New York, do non-physicians now provide surgical abortions) may also have different implications for medical abortion. Given that medical abortions involve a discrete sequence of steps—none of which involve surgery—many have noted that this modality may be especially suited to involvement of non-physicians, and in some locales, perhaps amenable to legal challenge. However, all these legal issues currently remain unclarified and hence, new providers must proceed as if they were still in effect (Borgmann & Jones, 2000). The net effect therefore of these myriad laws is that new providers, perhaps contemplating only a handful of mifepristone abortions per year, must become conversant with a legal apparatus unlike no other in contemporary medicine.

Internal issues

"Turf issues"

Accompanying the unique external challenges facing the adoption of mifepristone are some of the familiar "turf" issues of medicine, which are a factor here as elsewhere in the profession. For example, while abortion provision historically has been most tied to the specialty of obstetrics and gynecology, some family practice physicians and other generalists have long been involved in surgical abortion. And in spite of the well-documented shortage of abortion providers, some voices within obstetrics and gynecology have been resistant to the involvement of others. Mifepristone, moreover, as already noted, dramatically increases the potential for the involvement of not only non-obstetrician/gynecologists, but advanced practice clinicians or "midlevel providers" as well (Clinicians for Choice, 1996; Kaiser Family Foundation, 1997; National Abortion Federation, 1991). Furthermore, this potential for new providers is occurring simultaneously with the pronounced drop in the number of abortions overall in the US that began in the mid-1990s and continues through to the present (Henshaw, 1998). Though no concrete data is available on the implications of all these factors, one can speculate that this may have complicating effects, for example, competition between obstetrician/gynecologists and family practice residencies for the dwindling number of abortion patients if both departments within a hospital decide to do resident training in medical abortion, or conceivably, a reluctance of obstetrician/gynecologists to serve as surgical back-up for family practitioners in some cases, as anecdotal reports reaching us have suggested.

Fear of adverse events/"cowboys"

In all areas of medicine, practitioners have some trepidation of the "cowboys" among them—i.e. those who are oriented toward practicing medicine "recklessly", or who at least depart in significant ways from the protocols of most of their peers. Given the excellent safety record of abortion provision in the US (Council on Scientific Affairs American Medical Association, 1992), there is no reason to assume that the abortion field has more "cowboys" than other branches of medicine. Indeed, given that first-trimester abortion has been shown to be 10 times safer than childbirth (Hakim-Elahi, Tovell, & Burnhill, 1990), arguably this field attracts less incompetent providers. However, given the intense scrutiny that abortion provision receives, fear of the damage that could be done by an inept practitioner is especially strong. Indeed, although the Institute of Medicine recently estimated that between 44,000 and 98,000 Americans die each year as a result of medical errors (Kohn, Corrigan, & Donaldson, 2000), it is not lost on the abortion providing community that abortion-related deaths receive disproportionate attention and far more severe penalties than other categories of physicians—as testified by the recent conviction on manslaughter charges and the prison term of a California abortion provider whose patient died after a

missed perforation,[7] rather than the more typical civil penalties that are common elsewhere when medical mistakes occur.

Throughout the process leading up to FDA approval and continuing through to the present, antiabortionists have relentlessly campaigned about the alleged medical dangers of mifepristone (Boonstra, 2001; National Right to Life Committee, 2001a; Seckora, 2001). Some of these allegations pertain to the supposed properties of the drug itself—"chemical warfare attack on unborn Americans", as one group claims (Jasper, 2000); "mifepristone may cause breast cancer" was posted on another antiabortion website (Coalition on Abortion Breast Cancer, 2001). Such claims are easily dismissible—in fact, mifepristone has long intrigued scientists for its potential to *cure* certain forms of breast cancers. (The drug has already shown potential to treat some forms of other cancers, such as meningiomas, and "compassionate use trials" are underway for the latter. Feminist Majority, 2001). But other antiabortion critiques directly address the dangers of inappropriate patient management—i.e. that the patient could suffer serious injuries or even die of excessive bleeding if not monitored properly by the doctor administering the mifepristone. Hence, the specter of an inept or reckless practitioner is particularly worrisome for this movement. In short, as in all other fields of medicine, innovators in this field are anxious for competent physicians to take up this new modality—and for incompetent ones to avoid it. The crucial difference here between abortion providers and others is, as the logic of this paper suggests, that the stakes for the former are so much higher when mistakes are made.

In the approximately 6000 patients who had mifepristone abortions in the two US trials, no serious injuries or complications were reported; a few patients needed blood transfusions after the mifepristone regime. Since general distribution in the US starting in September 2000, there have been a handful of adverse events. There have been three reports of women who took mifepristone despite having ectopic pregnancies, with one resulting in a fatality; there has been one reported case of a serious and rare bacterial infection in a mifepristone patient (with an additional infection occurring in a mifepristone patient in Canada, which resulted in a fatality); and a report of a heart attack of a woman in her twenties, three days after completing the mifepristone–misoprostol regime. These events prompted the FDA to work with Danco, in April 2002, to issue a "Dear Dr." letter, which was sent to all those who had ordered mifepristone from the manufacturer. The letter reaffirmed the importance of ruling out ectopic pregnancies prior to mifepristone administration (as the drug is not effective in such cases), as well as the prescribing physician's obligation to inform the FDA of all such adverse events. The letter also stipulated that "no causal relationship has been established between the drug and the illnesses in any of the cases" (Okie, 2002).

There has been no suggestion, in any of the cases discussed in this letter, of any provider recklessness or incompetency. Following the release of the letter, the response of the antiabortion community to these events appeared to be slight. However, it is virtually certain that the antiabortion community will eventually attempt to use these and other reported serious complications for political gain. What makes the potential defense of mifepristone by the pro-choice community particularly complex is the lack of an adequate database of all patient outcomes. Although numbers for the trial participants have been carefully monitored, there is no reliable way of knowing how many mifepristone abortions are currently taking place in the US, now that the drug is available for general use, and by what kinds of practitioners. In contrast to other pharmaceutical companies that seek to disseminate information on usage and provider preference for their medications, Danco has guaranteed the absolute confidentiality of all providers using or inquiry about mifepristone. Thus, as these and future adverse events come to be debated, there will be an insufficient larger context in for defenders of mifepristone in which to place such an event.

Fear of non-compliant patients

Finally, mifepristone abortions involve unique issues of patient "compliance" that are typically not an issue with surgical abortions. While the latter can typically be completed in one patient visit, the former involves two, and sometimes three office visits: the patient is given the mifepristone at the first visit; then, depending on which regime for misoprostol the provider uses, the patient is either told to return to the office for misoprostol insertion or given the second drug to be inserted at home; all patients are required to return for a final visit to ascertain that the procedure has been completed. Furthermore, the mifepristone regime involves more

[7] In 1996, the Riverside County, California District Attorney arrested and charged Dr. Bruce Steir, an abortion provider, with second-degree murder of a woman who underwent a second-trimester abortion and died several hours later from complications of a perforated uterus. Dr. Steir was forced to turn over his license, and in 2000, Dr. Steir accepted a plea bargain of involuntary manslaughter serving 6 months on a 1-year jail sentence (Reproductive Freedom Task Force, 2000). On February 1, 2001, Dr. James Pendergraft, a high-profile African-American abortion provider, was convicted of Federal extortion in Ocala Florida, and sentenced to 46 months in Federal prison, 2 years probation upon his release, and $25,000 fine (Reproductive Freedom Task Force, 2001). Advocates argue that these two cases represent a new front of attacks on abortion providers, that of politically motivated criminal prosecutions (Reproductive Freedom Task Force, 2001).

patient counseling, including extensive instructions on when a phone call back to the office is warranted, especially in cases of excessive bleeding.

Mifepristone abortions, in short, involve health care providers having to cede some degree of control to their patients, an already difficult issue for some health professionals, and one made even more complex, as this paper argues, by the high degree of scrutiny that is always present in abortion. Thus, early research on surgical abortion providers who began to incorporate mifepristone into their practices showed some ambivalence about this loss of control, and fears about patients who would not comply with the more complex regimes associated with the new procedure (Simonds, Ellertson, Winikoff, & Springer, 2001; Joffe, 1999).

Conclusions: sociological implications

Speculating about the future of mifepristone in the US, probably the most likely scenario in the immediate future is a steady and continuing adoption of the drug by surgical providers. The use of this drug by "new" providers will, for the various reasons cited above, probably be quite gradual. Abortion rights supporters can be cautiously optimistic about more non-surgical providers offering mifepristone in the future, as more and more reports of successful use reach the medical literature, as the cumulative effects of various training initiatives underway by pro-choice medical organizations take hold, and most significantly, if American women become educated about this drug and ask their primary care providers to provide it. Such a slow but steady scenario, of course, depends on a fairly stable political environment surrounding abortion. Should changes in the Supreme Court lead to a repeal of Roe v Wade, or should even the present Court follow the lead of antiabortionists in seeking to establish the legal personhood of the "unborn", as several judicial and legislative overtures are now seeking to accomplish[8] or should violence against abortion providers escalate and go unchecked in the Justice department, the promise of mifepristone could be stalled indefinitely. And, as already suggested, should a high profile "adverse event" occur, this could spur the FDA or Congress to impose more stringent restrictions on who can prescribe mifepristone. Even without these political scenarios, though, our argument in this paper is that at almost every level, the adaptation of a quite simple medical regime is rendered more cumbersome by the unique circumstances surrounding abortion.

The still unfolding story of the coming of mifepristone to the United States carries several intriguing sociological implications. First, this saga casts strong doubt on the inevitability of "technological determinism" within medicine (Atkinson, 1995; Banta & Luce, 1993; McKinlay & Hafferty, 1993; Novaes, 2000; Turner & Samson, 1995)—at least when such a socially controversial medical procedure is involved. The fact is that a new and proven effective technological innovation became available for one of the most commonly sought medical procedures in the US—some 43% of American women, according to the Alan Guttmacher Institute, will have at least one abortion by the time they are 45 years old (AGI, 2000). This innovation, moreover, could potentially eliminate the need for surgery for many of the abortions now taking place within the United States (for example, the approximately 50% of abortions that occur within the first 7 weeks of pregnancy). Yet these features did not smoothly translate into the widespread adoption of this technique. Nor is this likely to change quickly in the future.

Rather, the various challenges noted in this paper to routinize the use of mifepristone give further confirmation to the extraordinary degree to which the medical nature of abortion provision has been overwhelmed by larger abortion politics. Certainly, the mifepristone story in the US to date gives powerful support to Latour's observation that "science is politics by other means" (Latour, 1988); see also Clarke & Montini, 1993).

But the mifepristone struggle in the U.S is far from over. We use the word "struggle" advisedly. Although physicians and other health care workers are most often spoken about sociologically using the language of the sociology of professions (Freidson, 1970a, 1970b) and although certain concepts from this tradition are undeniably relevant here (for example, the turf wars between specialties), we believe the field of social movements offers another quite useful frame in which to understand the mifepristone story to date, and to speculate about the future. Though social movement activism with regard to health care and medicine is typically conceptualized within sociology in terms of lay mobilization against professional dominance and authority (Epstein, 1996; Ruzek, Clarke, & Olesen, 1997) there is also a nascent tradition of scholarship at the interface of social movements and health care research which focuses on medical personnel themselves as social movement activists (Hoffman, 1989; Lo, M., 2002).

Social movements, as we know, create "counter movements" (Lo, C., 1982)—and just as the 1973 *Roe v Wade* decision created the modern "prolife" movement (Luker, 1984), so the excesses of the latter helped create and sustain activist wings within the traditionally

[8] Efforts to extend fetal personhood are occurring at the federal and state levels. These efforts are reflected in the passage of the "Unborn Victims of Violence Act" in 2001 (Michelman, 2001), and in the construction of bans on so-called "partial-birth abortions" (Center for Reproductive Law and Policy, 1998).

apolitical medical profession, as demonstrated by the founding of Medical Students for Choice after the first killing of an abortion provider in 1993 (Joffe, Anderson, & Steinauer, 1998). Thus, when speculating about the future of mifepristone in the US, we can anticipate more and more engagement by pro-choice health care providers in various "political" activities traditionally associated with social movements (and thus, historically labeled as "unprofessional" by many of their medical colleagues).

In this vein, this paper concludes with an observation on the quite different political environments after two crucial developments in abortion policy in the US: the *Roe v. Wade* decision in 1973, and the FDA approval of mifepristone in 2000. After the first—itself achieved by both a politicized wing of the medical community and feminist activists (Joffe, 1995; Luker, 1984; Petchesky, 1984)—the political momentum was seized, as mentioned above, by a newly created "prolife movement". The pro-choice forces within medicine and feminism relaxed their vigilance, and the mainstream medical establishment, though on record as approving of legal abortion, maintained a distance from abortion, and the immediate post-*Roe* period was noteworthy for what did *not* happen in medicine—i.e. most hospitals did not establish abortion clinics, residencies for the most part did not establish training programs, medical organizations (with the notable exception for the American Public Health Association) did not establish standards for abortion care and so on (Joffe, 1995).

The situation, in the aftermath of the FDA action of September 2000, is a quite different one. In large part because of the battles fought over the 27 years since *Roe*, there are now several highly organized abortion rights groups within organized medicine—the National Abortion Federation, Physicians for Reproductive Choice and Health, Medical Students for Choice, pro-choice blocs within the American Medical Women's Association, and within such specialty groups as the Society for Teachers of Family Medicine and ACOG. These groups have been proactive at every stage of the coming of mifepristone to the U.S: testifying before the FDA, promulgating standards of care, speaking to the media, and perhaps most importantly, as noted above, in offering training to health care providers in a variety of settings about the use of mifepristone. Besides such formal activities, these physicians committed to furthering the adoption of mifepristone work tirelessly on a more informal level to facilitate mifepristone use among medical colleagues: for example, they help novice users maneuver the intricacies of ordering the drug, advise on insurance reimbursement and malpractice options, and make themselves available to new users to offer support about any issues that emerge. These pro-choice physicians also undertake advocacy work within medical bureaucracies—for example, by lobbying sympathetic but wary residency directors in obstetrics and gynecology and family practice programs to allow training in medical abortion, or by advocating the inclusion of sessions on medical abortion on the conference programs of professional associations, such as ACOG and the American Academy of Family Practice.

This is hardly to suggest that such activities, in and of themselves, can completely compensate for the difficulties, discussed throughout this paper, in "routinizing" mifepristone within US medicine. Indeed, the very reluctance of otherwise sympathetic health care professionals to appear "too political" may impede the ability of this new drug to attract new abortion providers. But the range of efforts now underway to mainstream mifepristone makes amply clear that in the quite exceptional case of abortion, those physicians who are currently trying to promote this new abortion regime can most fruitfully be understood, from a sociological perspective, as political activists as well as health care professionals. How these proponents negotiate these two identities—historically seen as at odds with each other—will be an important determinant of the fate of mifepristone in the United States.

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CHAPTER 11: SUBMITTED ARTICLE

"MALPRACTICE COVERAGE OF MEDICATION ABORTION IN THE PRIMARY CARE SETTING: CURRENT PRACTICE, FUTURE DIRECTIONS

Submitted to *Women's Health Issues*

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Abstract:

Introduction: Primary care physicians interested in providing medication abortion may be unsure whether their professional liability insurance policies cover this care. This uncertainty may hinder medication abortion provision in the primary care setting.

Methods: We analyze the legal and regulatory aspects of malpractice coverage relevant to medication abortion provision. We perform a general review of applicable state laws nationwide, and a more detailed examination of relevant law in four representative states: New York, California, Texas, and Missouri.

Results: Relevant features of malpractice coverage include a lack of distinction between medication and surgical abortion; the existence of "abortion riders" in some policies; and the importance of the specialty classification. In a policy that does not explicitly include or exclude abortion, coverage of medication abortion will be construed based on both the application and the policy document. Anti-discrimination laws and prohibitions on unfair trade practices may provide limited recourse to physicians challenging high rates for coverage of the provision of medication abortion. We categorize the likelihood of coverage for medication abortion, given different policy terms and application content. Strategies for systems level change are discussed.

Conclusion: Ensuring liability coverage of medication abortion is important for realizing mifepristone's potential for improving access to abortion care in the United States.

Introduction

The diffusion of new healthcare technologies requires a wide range of enabling factors, ranging from the training of clinicians to the creating of CPT/ICD codes for reimbursement. If the technology is a new pharmaceutical product, it will need to be stocked by pharmacies and included on hospital and health plan formularies. New diagnostic tests may require the purchasing of additional equipment by either the health care provider or the laboratory. In some cases, ensuring that a particular procedure is included in malpractice liability coverage may also be important.

In September 2000, the U.S. Food and Drug Administration approved the use of mifepristone (also known as RU-486, or the "abortion pill") for induced abortion. The availability of a medication regimen for abortion means that providing abortion care no longer requires training in instrumentation of the uterus. As such, a wider range of primary care providers, including those who currently do not provide aspiration or surgical abortion, may be interested in including medication abortion provision in their practice.

Unfortunately, abortion has been historically recognized as a "surgical" service by both payers and liability carriers. Although aspiration abortion techniques used to terminate early (first trimester) pregnancy are simple, low-risk, office-based procedures, abortion is often listed on liability carrier procedure lists alongside gynecological interventions that require limited surgical training. Thus, primary care clinicians considering providing medication abortion may be uncertain about whether *medication* abortion is included in a malpractice policy that does not cover surgical gynecological procedures. A 2001 Kaiser Family Foundation survey found that nearly half of general

practice physicians (defined as family practice physicians, internists, and general practitioners) did not know whether their malpractice insurance covered the provision of medication for elective abortion.(Kaiser Family Foundation, 2001)

Because malpractice coverage represents a potential barrier to the provision of medication abortion in the primary care setting, we analyze the legal and regulatory aspects of malpractice coverage relevant to medication abortion provision. We identify general principles of malpractice coverage and describe legal and regulatory frameworks likely to affect coverage of medication abortion. We offer basic guidance to clinicians trying to determine whether medication abortion is included in their coverage, and suggest possible strategies for moving toward sensible, reasonable malpractice policies for medication abortion. This information is provided to help clinicians and advocates understand the "lay of the land" for malpractice insurance and should not replace individual legal advice.

Methods

Our legal analysis was guided by preliminary interviews with a small sample of stakeholders including clinicians (both those who do and do not currently provide abortion care), clinic administrators, advocates, and malpractice insurance brokers and writers representing companies who currently provide abortion coverage. We also reviewed medical malpractice insurance policies and applications from three insurers.

Our legal research encompassed a general review of applicable state laws nationwide, and a more detailed examination of the relevant law in four representative states: New York, California, Texas, and Missouri.

Results

Features of malpractice coverage relevant to medication abortion

We identified several features of malpractice coverage relevant to medication abortion. These include a lack of distinction between coverage for medication abortion and for surgical abortion; the existence in some policies of "abortion riders;" and the role of the specialty classification.

To be consistent with the terminology used by malpractice insurers, we use "surgical abortion" to refer to a heterogeneous group of procedures, including aspiration abortion as well as more complex instrumentation abortion procedures used in the later second trimester of pregnancy.

No distinction between surgical and medication abortion

Currently, the insurance industry does not distinguish between medication and surgical abortion, and provides no avenue for separate coverage of medication abortion. Physicians who provide prenatal care, obstetrics, or surgical abortion may have policies that explicitly include abortion, without distinguishing between medication and surgical methods. No such specific inclusion will ordinarily appear in the policy of a physician who does not provide services in any of these three areas. Some insurance policies contain explicit abortion exclusions, which refer to abortion generally or to surgical abortion specifically.

Abortion riders can be costly

Some physicians who do not offer surgical abortion have sought clarification directly from their liability carriers about coverage of medication abortion. These physicians have been told that they must purchase an abortion rider that covers both

medication and surgical abortion. An "abortion rider" is an amendment to an insurance policy that explicitly covers both medication and surgical abortion. These riders can be expensive, and have been estimated to cost $10,000 to $15,000 per year.

Specialty classification is important

One important factor affecting coverage is not found in the policy document itself, but in the physician's application for coverage. The application asks numerous questions about the physician's practice and often asks specific questions about whether the physician performs abortions. The application also asks the physician in which specialty classification s/he wishes the policy to be issued. The policy will ordinarily provide coverage only for the professional services that are permitted to be performed under that specialty. Some primary care physicians (non-obstetrician-gynecologists) have contacted their insurers to ask whether medication abortion is included and have been informed that abortion is not within the practice area of non obstetrician-gynecologists, with no distinction made between medication and surgical abortion.

Legal and regulatory principles: how are disputes resolved?

Primary care clinicians who do not provide surgical abortion but who wish to prescribe mifepristone for medication abortion face ambiguity in their malpractice policies' coverage of medication abortion. These physicians may not be providing specialty obstetrical or gynecological care, may not have an abortion rider, and may not have a policy that specifically excludes coverage of medication abortion. We present the legal and regulatory principles that influence how courts might construe coverage of medication abortion in a policy that does not explicitly include or exclude abortion. Because state laws vary widely and are subject to change by legislatures and courts, our

analysis consists only of a discussion of general legal principles. Persons wishing to understand the particular laws of their states should therefore seek individual legal advice.

How will the contract be interpreted?

Malpractice coverage involves a contract between the liability carrier and the clinician. In resolving any disputes, the relevant terms of the contract may include not only the terms included in the policy document itself, but also those in the application and the declarations page.[1] In interpreting the terms of the contract, the "plain meaning rule" means that the generally accepted meaning of the language is used.[2] The court's paramount goal is to determine the intent of the parties.[3] Unless there is some ambiguity, this intent will be determined only from the contract, rather than from outside evidence.[4] Where there is ambiguity, however, a court may look to the "course of dealings" between the parties--such as prior indications of coverage--to determine the policy's intended scope.[5] Where the intent of the parties is ambiguous, the ambiguity is generally resolved in favor of the policy holder.[6] Thus, if the insurer wishes to exclude certain acts from coverage, the policy must be specific as to those exclusions.[7]

States prohibit unfair discrimination in the setting of insurance rates

All states have provisions that prohibit unfair discrimination in the setting of insurance rates, typically prohibiting the imposition of rates that are "excessive, inadequate or unfairly discriminatory."[8] In some states, including California and Texas, anti-discrimination laws have been interpreted narrowly, to apply only to "suspect" characteristics such as gender, age, or marital status.[9] Other states—including New York and Missouri—also prohibit unfair discrimination among risks, preventing insurance

companies from imposing different insurance rates for similar risk.[10] States also have regulatory mechanisms that oversee the setting of rates; these mechanisms vary from state to state.

Laws prohibit unfair trade practices

State laws prohibiting unfair trade practices apply to virtually every aspect of the insurer's conduct. These laws, however, usually prohibit only conduct that is deceptive or misleading.[11] Similarly, consumer protection laws, which address improper business practices, prohibit conduct that is false, misleading or deceptive.[12] Generally, to be prohibited by the consumer protection statutes, business practices must have an adverse impact on consumers at large—not just on a single consumer.[13]

Discussion: What are the implications for practice?

Determining whether medication abortion is covered

Given the current landscape of malpractice coverage, practicing physicians who are considering providing medication abortion may face ambiguity in their malpractice coverage, unless they are already providing surgical abortions. We categorize the likelihood of coverage for medication abortion, given different policy terms and application content.

Category 1. Very high likelihood that medication abortion is covered.

- Policy explicitly includes abortion (unspecified surgical/medication, or surgical specifically) **OR**

- Physician states on application that she provides abortion (unspecified surgical/medication, or surgical specifically), and policy does not explicitly exclude abortion generally or medication abortion specifically

Category 2. Some likelihood that medical abortion is covered, but less clear (Discussed below)

- Medication abortion falls within the scope of the medical specialty classification designated by the physician on her or her insurance application **AND**
- Neither the policy nor the application mentions abortion **OR**
- Policy excludes *surgical* abortion, with no mention of medication abortion **OR**
- Physician states in application that she does not provide *surgical* abortion, with no mention of medication abortion

Category 3: Very low likelihood that medication abortion is covered.

- Policy explicitly excludes abortion, without specifying surgical or medication **OR**
- Physician states on application that she does not provide abortion, and type of abortion (surgical versus medication) is not specified

Category Two: Dealing with Ambiguity

In Category 2, the critical question will be whether medication abortion coverage is implied as a service that falls within the scope of practice of the physician's specialty classification. For medical specialties such as general practice, internal medicine, family practice, and obstetrics and gynecology, a strong argument can be made that medication

abortion is within the physician's scope of practice (Grimes & Creinin, 2004; Prine & Lesnewski, 2005). Accordingly, coverage for medication abortion could probably be implied under insurance contracts for those specialty classifications.

Based on this assessment, a physician whose insurance contract falls into this category has two general alternatives. The physician can assess—on the basis of the principles discussed here as well as individual legal advice—the likelihood that his/her current insurance policy covers medication abortion. If the provider feels comfortable about that coverage and is willing to accept the risks of possible non-coverage, s/he could decide to provide medication abortion without discussing it with the insurer.

Alternatively, if the physician desires greater certainty or thinks it is fairly likely that medication abortion is not covered, the physician can notify his/her insurer of his/her intention to provide medication abortions. In this case, the physician may face an increase in insurance premium in order to obtain this coverage.

Can rate increases be challenged?

Abortion, particularly medication abortion, is very safe, with an overall case-fatality rate of less than 1 death per 100,000 procedures (Henderson, Hwang, Harper, & Stewart, 2005), compared to roughly five deaths per 100,000 prescriptions of sildenafil (Viagra) (Mitka, 2000). When faced with a rate increase for abortion coverage, clinicians and advocates may wish to know what avenues are available for contesting the charges as being unreasonable based on the risk.

If the insurance contract covers medication abortion—pursuant to the principles discussed—then the insurer is bound to provide coverage at the premium for which the policy was issued. If, on the other hand, the policy does not cover medication abortion,

the insurer could impose charges for that coverage, subject to the protections of anti-discrimination laws, consumer protection laws, and unfair business practices laws. However, as discussed above, these protections are limited. State bodies that oversee rate-setting may be another possible avenue for seeking relief from excessive rates for medication abortion coverage.

Strategies for Change

To ensure affordable malpractice coverage for providers of medication abortion, work is needed in multiple areas. Because riders to cover only medication abortion are not generally available, providers may attempt to form a pool that could bargain collectively to obtain such a rider. This option could be investigated by professional organizations or other groups of clinicians.

Because coverage decisions may be made on the basis of the scope of practice in a particular specialty, efforts to reinforce medication abortion as an appropriate part of primary care practice are also helpful. Research publications, consensus statements, guidelines, and presentations at professional conferences can all contribute to ensuring that management of early unintended pregnancy, including abortion care, continues to be recognized as part of primary care practice.

In order to guide evidence-based rate-setting, risk analyses can compare the safety of medication abortion to that of other primary care treatments or procedures. Education and outreach to policymakers and regulatory agencies can help increase awareness of the importance of such evidence-based malpractice coverage.

Conclusion

Abortion care is an important component of health care for women. In the United States, nearly half of all pregnancies are unintended, and half of these end in abortion. Over forty percent of women are estimated to have had an abortion by the age of 45 (Henshaw, 1998). Despite the need for abortion care, there are fewer than 2,000 providers in the United States (Finer & Henshaw, 2003). A 2001 Kaiser Family Foundation survey found that just 1% of "general practice physicians" (including family practice physicians, internists, and general practitioners) were routinely providing abortion care (The Henry J. Kaiser Family Foundation, 2001).

Medication abortion is an important option for the early management of unintended pregnancy in the primary care setting. Ensuring coverage of medication abortion care under existing policies and/or through affordable medication abortion riders is important for realizing mifepristone's potential for improving access to abortion care in the United States. Efforts by clinicians, researchers, policymakers and advocates can all contribute to sensible and fair malpractice coverage for medication abortion.

Notes

1. *See, e.g.*, Holmes' Appleman on Insurance 2d § 5.4 at 80 (1996).; Bender, The Law of Liability Insurance § 15; *First Nat. Bank of Malden v. Farmers New World Life Ins. Co.*, 455 S.W.2d 517, 523-24 (Mo. App. 1970; *Massachusetts Mut. Life Ins. Co. v. Lord*, 238 N.Y.S.2d 222, 224 (N.Y. App. Div. 1963); *Mennen v. J.P. Morgan & Co., Inc.*, 666 N.Y.S.2d 975 (N.Y. 1997); *Binasco v. Break-Away Demolition Corp.*, 681 N.Y.S.2d 309 (N.Y. App. Div. 1998); *Mobil Exploration and Producing U.S., Inc. v. Dover Energy*, 56 S.W.3d 772, 777 (Tex. App. 2001).

2. *See, e.g., Manneck v. Lawyers Title Ins. Corp.*, 33 Cal. Rptr. 2d 771 (Cal. 1994); *O'Connor v. State Farm Mut. Auto Ins. Co.*, 831 S.W. 2d 748 (Mo. App. 1992); *Granite Construction Co. v. Bituminous Ins. Co.*, 832 S.W. 2d 427 (Tex. App. 1991); *Comm. of State Ins. Fund v. INA*, 607 N.E. 2d 795 (N.Y. 1992); Holmes' Appleman on Insurance 2d § 5.3 (1996).

3. *See, e.g., Automobile Club Inter-Ins. Exchange v. Medrano*, 83 S.W.3d 632, 638 (Mo. App. 2002); *Carlton v. Trinity Universal Ins. Co.*, 32 S.W.3d 454, 459 (Tex. App. 2000); *AIU Ins. Co. v. Superior Court* 799 P.2d 1253 (Cal. 1990).

4. *See, e.g., In re Will of Ault*, 615 N.Y.S.2d 681 (N.Y. App. Div. 1994).

5. *See, e.g., State and County Mut. Fire Ins. Co. v. Macias*, 83 S.W.3d 304, 306-07 (Tex. App. 2002), *rev'd on other grounds,* 123 S.W. 3d 271 (Tex. 2004); *McCarty v. Langdeau*, 337 S.W.2d 407, 413 (Tex. Civ. App. 1960); *Haggard Hauling & Rigging Co. v. Stonewall Ins. Co.*, 852 S.W. 2d 396 (Mo. App. 1993);

Waynesville Sec. Bank v. Stuyvesant Ins. Co., 499 S.W.2d 218, 221(Mo. App. 1973); *see also* Holmes' Appleman on Insurance 2d § 5.4 at 81-82 (1996).

6. *See, e.g., Automobile Club Inter-Ins. Exchange v. Medrano*, 83 S.W. 3d 632, 638-39 (Mo. App. 2002); *Bedford Cent. Sch. Dist. v. Commercial Union Ins. Co.*, 742 N.Y.S. 2d 671, 673 (N.Y. App. Div. 2002); *LaJolla Beach & Tennis Club, Inc. v. Industrial Indemnity Co.*, 884 P.2d 1048 (Cal. 1994); *Phillips v. Union Bankers Ins. Co.*, 812 S.W.2d 616 (Tex. App. 1991); Restatement (Second) of Contracts § 206.

7. *See, e.g., Seaboard Sur. Co. v. Gillette Co.*, 476 N.E.2d 272 (N.Y. App. Div. 1984); *Stewart v. Estate of Bohnert*, 162 Cal. Rptr. 126 (Cal. App. 1980); *Pepper Industries, Inc. v. Home Ins. Co.*, 134 Cal. Rptr. 904 (Cal. App. 1977); *Bright v. New York Life Ins. Co.*, 546 S.W.2d 145, 146-47 (Tex. Civ. App. 1977); see also Restatement (Second) of Contracts § 206; Holmes' Appleman on Insurance 2d § 7.2 at 276-77 (1996)

8. *See e.g.*, Mo. Rev. Stat. § 379.318; Keeton and Widiss, Insurance Law: A Guide to Fundamental Principles, Legal Doctrines, and Commercial Practices § 8.4(a) (1988).

9. *See e.g.*, Cal. Ins. Code § 11732.5; *Mackey v. Bristol West Ins. Services of Cal., Inc.*, 130 Cal. Rptr. 2d 536, 552 (Cal. App. 1 Dist. 2003); Tex. Ins. Code § 5.15-1; *Birnbaum v. Alliance of Am. Ins.*, 994 S.W. 2d 766, 770 (Tex. App. 1999).

10. *See e.g.*, Mo. Rev. Stat. § 379.318`; N.Y. Ins. L. § 2243; N.Y. Ins. L. § 5505(b); *State Farm Fire and Cas. Co. v. Superintendent of Ins. of State. of N.Y.*, 556

N.Y.S.2d 893 (N.Y. App. Ct. 1990); *Insurance Comm'r v. Engelman*, 692 A.2d 474, 480 (Md. 1997).

11. *See, e.g.*, Mo. Rev. Stat. § 375.936; Cal. Ins. Code § 790.03; Tex. Ins. Code § 541.061 (Vernon Supp. 2005).

12. *See, e.g.*, N.Y. Gen. Bus. L. §§ 349 and 350; *Oswego Laborers' Local 214 Pension Fund v. Marine Midland Bank,* 647 N.E.2d 741 (N.Y. 1995); *St. Patrick's Home for the Aged and Infirm v. Laticrete Int'l, Inc.*, 264 A.D.2d 652 (N.Y. App. Div. 1999).

13. *See, e.g.*, *New York Univ. v. Continental Ins. Co.*, 662 N.E.2d 763.

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CHAPTER 12: PUBLISHED ARTICLE

"SIX FEET UNDER BRINGS ABORTION TO THE SURFACE"

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"Reprinted from *American Sexuality Magazine [online issue]* (1), "Six Feet Under Brings Abortion to the Surface," available at http://nsrc.sfsu.edu/HTMLArticle.cfm?Article=201&PageID=60&SID=2B9A6BF3307A77DA1465574290FD14ED, copyright (2004), with permission from the National Sexuality Resource Center (NSRC), Human Sexuality Studies Program, San Francisco State University."

Abortion is one of the most commonly performed medical procedures in the United States, but when was the last time you saw someone on TV have an abortion? Although there are over 1.3 million abortions ever year in the U.S., abortion is rarely depicted in mainstream television. While a decided majority of the U.S. population is pro-choice, television content appears to represent the voice of the pro-life constituency. Even with the growth of cable programming, which flaunts the rejection of conservative network standards related to language, violence, and sexuality, abortion continues to be an issue that seems too controversial to present in any substantial way. Despite "politically correct" attempts to pay lip service to supporting a woman's right to choose, it is rare indeed for a main female character to actually have an abortion.

In the routine television storyline, a woman confronted with an unintended pregnancy considers all her options--abortion, adoption, and continuing the pregnancy--only to decide to have the child or miraculously have a miscarriage. A recent example comes from the popular and award-winning series, Sex in the City. As the show's official HBO website explains, "(Miranda Hobbs) had every intention of having an abortion, but minutes before the procedure she had a change of heart and decided to keep the baby."[1] Years earlier another "feminist character," Murphy Brown, decided that age and resources allowed her to have the child "out-of-wedlock." Although she engendered Vice President Dan Quayle's ire, the network won support from abortion opposition groups who embraced Murphy's decision not to have an abortion. Dawson's mother on Dawson's Creek was actually talked out of an abortion by her son, and Andrea on

[1] Nixon, C. Miranda Hobbs. Home Box Office. Available at: http://www.hbo.com/city/cast/character/miranda_hobbes.shtml. Accessed July 29, 2003.

Beverly Hills 90210 decided to continue her pregnancy and to opt out of going to Yale University. In perhaps the most melodramatic storyline, Jo on Melrose Place chose to have her drug-dealing ex-boyfriend's baby, even though she was forced to kill the boyfriend to save her life. Although each of these women waxed poetically about supporting the right to choose, none of them actually chose to have an abortion.

For the women on TV who do not continue their unintended pregnancies, most often their pregnancies conveniently take care of themselves. Julia on Party of Five had a miscarriage before she was able to get to the abortion clinic. Amanda on Melrose Place had a ruptured ectopic pregnancy that would leave her sterile. Like their counterparts who continued their pregnancies, these characters "seriously" considered having an abortion. Such a plot resolution allows TV producers and network officials to stir interest around the topic of abortion without having to deal with the impact on the storyline should a character choose to have a child or an abortion. Critics on both sides can be mollified: pro-choice supporters can envision that the woman "would have gone through with it" and abortion opponents can argue that the character would have changed her mind.

Some characters have been bold enough to admit having had an abortion in the past. However, even a show like Cagney and Lacey --which had two female protagonists and was considered very progressive--could only have a lead character admit to having had an abortion within the context of choosing to continue a current pregnancy. A few other television programs have used an abortion story-line including Law and Order: Criminal Intent which covered the killing of an abortion provider and ER in which a one-time client has an abortion. More recently, Everwood included the story of a young girl who finally obtains an abortion from another doctor after the main physician character

decides he can not provide the care for the girl. But only Maude in 1972 and Erica on All My Children in 1973 dared to have a main character obtain an abortion during the course of the show, until now.

In May 2003, HBO bravely broke a long-established taboo when Claire actually had an abortion on Six Feet Under. This action represents a very positive first step toward addressing a very common life experience for women. Despite this promising start, the storyline reverts to traditional pro-life messages in both its portrayal of abortion provision and in equating a fetus with a fully developed baby.

Episode Thirty-Eight: Abortion Provision

In Six Feet Under, episode thirty-eight, "Twilight" (directed by Kathy Bates and written by Craig Wright), Claire discovers that she is pregnant by her estranged boyfriend, Russell. The official HBO website summarizes the episode: "Claire makes a difficult choice as well: to terminate her pregnancy."2 Yet even though the episode doesn't show Claire's decisionmaking process, the nonchalant manner in which she asks Brenda for a ride to the clinic does not imply difficulty. "'Do you think you could give me a ride?' Claire asks. 'I have to get an abortion.'"[2] The website's description of the abortion decision as "difficult" foreshadows what is to come in episode thirty-nine, in which the producers of the show try to hedge their position on abortion by demonstrating Claire's conflicted feelings.

In this episode, Claire undergoes an abortion according to the worst stereotypes about abortion provision. The impersonal and highly medical portrayal of the procedure

[2] HBO. Six Feet Under: Episode 38 "Twilight". Home Box Office. Available at: http://www.hbo.com/sixfeetunder/episode/season3/sea3_eps12.shtml. Accessed July 29, 2003.

demonstrates the extent to which the anti-choice rhetoric of abortion has become an accepted interpretation of reality. At the clinic, Claire and Brenda sit in a waiting room surrounded by other women, devoid of any positive support. Claire is called from the waiting room with all the other women, in mass, and is shown in a room wearing a surgical gown undergoing what appears to be general anesthesia.

The viewer is led to believe that Claire's experience is routine for abortion. In fact, the episode's name, "Twilight," is thought to stand for the type of anesthesia used for some abortion procedures. Abortion is portrayed as starkly medical and complicated, as well as grossly impersonal.

Postings on the *Six Feet Under* (SFU) Bulletin Board[3] demonstrate the extent to which this image took hold. One fan asks, "Do abortion clinics really function in such a factory like manner?"(simiulacra 5/18/03). Others respond:

> "The Abortions 'R Us place was like a factory." (isyou 5/18/03)
> "...the way they called all the girl's names; like hearding (sic) animals (at the clinic)." (KLV21 6/2/03)
> "The writers on the show were treating abortion exactly like it is in real life...Abortion clinics do 'cattle call' the patients in and it is usually an emotional hardship on the pregnant women." (Karen2240 6/2/03)
> "YOU GOT THAT RIGHT! It is done in a 'cattle call' fashion and it couldn't be any more accurate than that, as unfortunate as it may seem." (bajoros 6/2/03)
> "The writers simply let it 'all hang out', showing a typical clinic without comment or judgement (sic). If it's an eye opener to the audience, then good." (meridithc6/2/03)

Why Not The "Abortion Pill?"

One of the hopes of the 2000 U.S. approval of mifepristone (also known as the "abortion pill" or RU486 in France) was that abortion could be performed in regular

[3] HBO Six Feet Under Bulletin Boards. Available at: http://boards.hbo.com/forum.jsp?forum=117. Accessed July 29, 2003.

health care providers' offices, rather than in clinics, with minimal medical intervention. The negative imagery portrayed in these bulletin board postings by *Six Feet Under* fans reflect the importance of continuing the effort to integrate abortion back into primary care, and to continue to move away from the idea that abortion is provided according to an impersonal clinic-based model.

With that said, it is also important to acknowledge that most abortion clinics do not operate in such a manner. Instead, the majority of early abortions are performed under local anesthesia while a patient wears her own clothes rather than a surgical gown. Women are also given individualized, personal, and compassionate care. Research on the quality of abortion care has demonstrated overwhelmingly high satisfaction among abortion clients.[4] The dialogue between the *Six Feet Under* fans exposes the extent to which anti-abortion perspectives have become the accepted interpretation. The fan dialogue about Six Feet Under also exposes the damage done by television's failure to realistically portray abortion provision.

That *Six Feet Under* does not include medical abortion is disappointing. Rather than reinforcing old stereotypes, the writers and producers could have explored new ground. They could have educated the public about medical abortion while also providing entertaining television. In fact the confusion and lack of knowledge about medical abortion is apparent in the following exchange among Six Feet Under fans:[5]

> "...These days, many early pregnancies are ended with RU486. Are the prolifers picketing drugstores these days?" (sandgann 5/19/03).

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[4] The Picker Institute. From The Patient's Perspective: Quality of Abortion Care. Menlo Park, CA: Kaiser Family Foundation; May 1999.
[5] HBO Six Feet Under Bulletin Boards. Available at: http://boards.hbo.com/forum.jsp?forum=117. Accessed July 29, 2003.

"...RU486 isn't available at the drugstore, either. You have to get it at a clinic, and you have to get it the very next morning." (titannia 5/19/03).
"You're thinking of the morning-after pill. That's different from RU-486" (wolfgirl 6/4/03).
"You can only get the abortion pill at an abortion clinic, and you have to (be) watched while it takes effect..." (Maggiespancake 5/19/03).

Episode Thirty-Nine: A Fetus Becomes a Baby in the "Afterlife"

The greatest disappointment of Six Feet Under's groundbreaking abortion story is its attempt to "balance" appeals to both "pro-choice" and "pro-life" viewers. While episode thirty-eight shows Claire having an abortion without ramifications, episode thirty-nine ("I'm Sorry, I'm Lost," directed by Alan Ball and written by Jill Solway) appeals directly to those who might have opposed her decision. The HBO official website describes this episode: "Claire remains conflicted over the abortion...." During the episode her dead father takes her on a visit to the afterlife where she "encounters beatific versions of people she's cared for and lost: Lisa, Gabe Dimas - and the baby she decided not to have."[6] During her exchange with Lisa, Claire is asked to care for Lisa's living child in exchange for Lisa caring for the "baby" Claire aborted. As one fan noted: "What makes me wonder about the Lisa/Claire exchange is why they used a full-term baby as Claire's baby and everyone else in the 'afterlife' were exactly the age they were when they died..." (mpasq 6/2/03).[7]

Again, postings to the *Six Feet Under* fans bulletin board[7]demonstrate this limitations of the approach and its direct appeal to those who oppose abortion:

[6] HBO. Six Feet Under: Episode 39 "I'm Sorry, I'm Lost". Home Box Office. Available at: http://www.hbo.com/sixfeetunder/episode/season3/sea3_eps13.shtml. Accessed July 29, 2003.
[7] HBO Six Feet Under Bulletin Boards. Available at: http://boards.hbo.com/forum.jsp?forum=117. Accessed July 29, 2003.

"Although I do not identify myself in the pro-life (or anti-abortion) camp, I cannot interpret the image of Claire seeing her aborted baby with Lisa in the afterlife as anything but a pro-life statement..." (russjourn 6/1/03).

"Yet they had her have the abortion in the first place? I think the writers did a great job of trying to please everyone. The prochoicers for letting her decide to have the abortion and the pro-lifers for giving the baby such a peaceful place of rest" (NakkisGirl 6/1/03).

"...I did think it was strange that the guy who wrote "twilight" said that SFU would be taking a no opinion stance on the abortion thing. (The heaven) scene made a definite statement" (1heather247 6/1/03).

What is clear from this exchange is the how directly the fans understand the storyline to be part of a larger public dialogue about abortion.

Conclusion

Six Feet Under should be commended for its courage in having a main character actually choose to have an abortion. At the same time, however, the show reinforces old images of abortion provision and makes an overt appeal to abortion opponents. Criticism of the coverage of abortion on Six Feet Under should not discourage other shows from taking the bold step to have main characters choose to have abortions when faced with unintended pregnancies. Rather, the limitations explored in this review should serve as appeals to writers and producers to forge ahead and explore new ground, instead of trying to find compromises between the "pro-choice" and the "pro-life" positions. Abortion remains fiercely polemic, and in that lays its appeal as a plot line for courageous television.

Television, however, can be used as a force in changing the way we feel about issues. Thirty years ago it would have seemed impossible to include a positive story-line about a gay character. Today, however, shows such as Six Feet Under, Will & Grace, and Ellen have unapologetically presented gay characters. In these shows, the related

storylines haveof being gay in the world. These characters are allowed to have full lives, relationships, and to integrate being gay with other aspects of the plot. In contrast, just one main TV character has had an abortion in thirty years.

Only by presenting abortion as what it is—a commonplace reality—the media can move away from simply presenting conventional stories, and begin to reflect the complexity and individuality of women's experiences. Women should be allowed to have abortions and talk about them, without blatant attempts to pacify those who oppose abortion. HBO's tentative first step should not be the last one.

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CHAPTER 13: SUBMITTED ARTICLE

'WHAT'S DIFFERENT ABOUT HOW PHYSICIANS LEARN ABOUT GENERAL WOMEN'S HEALTH AND HOW THEY LEARN ABOUT MEDICATION ABORTION?':

A SMALL QUALITATIVE STUDY OF PHYSICIANS IN RURAL ARKANSAS

Submitted to *Health*

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Abstract

This paper reports on a small qualitative study to gather information from community-based physicians practicing in Arkansas in a county without an abortion providers. The project's goal was to understand how these physicians routinely learn about new women's health advances to help guide the development of an intervention to expand the availability of medication abortion services in underserved areas. Using semi-structured interviews, physicians were asked to explain current health care provisions practices and recent adoptions of new techniques or treatments. Data from qualitative interviews with primary care physicians in Arkansas presents a preliminary picture of how 'women's health' providers learn about new advances and what role the pharmaceutical companies are playing in that process. Supporting literature is reviewed to locate these results within larger explorations of the pharmaceutical industries efforts to influence physician prescribing behavior. Two topics are explored in more detail, depression and anxiety management in women, and oral contraceptive preference of patients. Comparisons are made between the usual process for information dissemination for non-abortion health care and that of abortion technologies. Based on these results, recommendations are made for efforts seeking to facilitate provider adoption of mifepristone for medication abortion.

Key Words: women's health, abortion, mifepristone, detailing

Introduction

Annually over 1.3 million abortions are performed in the United States. Despite the ongoing need for services the number of abortion providers continues to decline. Abortion care is now available only at approximately two thousand clinical locations. These facilities are concentrated in urban centers, maldistributed across and within states. Currently 10 states have one or fewer abortion provider for every 100,000 women of reproductive age and eighty-six percent of all US counties do not have an identified abortion provider (Finer & Henshaw, 2003).

When mifepristone (known as RU486 in France and most commonly as 'the abortion pill') received US FDA approval in September 2000, many advocates expected the drug to be quickly adopted by thousands of physicians not currently offering abortions, thereby reversing the decline in the number of abortion providers. Since the FDA approval, however, the mainstream media has reported that the uptake of this technology is slower than originally predicted (Gellene, 2001; Mundy, 2001). While there are many hypotheses as to the reasons for this delay, to date no studies have examined the diffusion of this technology in the context of change within the larger clinical field of how advances in women's health are promoted.

This article uses data from interviews conducted with primary care physicians in one underserved state, Arkansas, to posit that one reason why medication abortion (abortions performed using the drug mifepristone, aka RU486 or the "abortion pill") has not been adopted is that it is not 'sold' like other women's health technologies. Data from qualitative interviews with physicians is combined with the available literature to presents a preliminary picture of how modern 'women's health' providers learn about

new medical advances and what role the pharmaceutical companies are playing in that process. The physicians' familiarity and comfort with treating depression and anxiety among women provides insight into the successful interplay of provider knowledge and disease construction as 'sold' by the pharmaceutical industry. Likewise, patient demand for a particular brand of oral contraceptive demonstrates the power of direct-to-consumer advertising. By comparison, mifepristone's turbulent history and the unique features of its' manufacturer and how it has been advertised may inhibit a similar trajectory for medication abortion.

A Primer on Medication Abortion

To induce a medication abortion a pregnant women initially takes the drug mifepristone and subsequently follows it with use of a second drug, misoprostol, a generic prostaglandin. The FDA labeling for Mifeprex®, the registered mifepristone product in the US, recommends use in women who are less than 49 days from their last menstrual period (LMP), aka seven weeks pregnant, and involves 600mg of mifepristone followed 48 hours later by 400mcg misoprostol taken orally. Care includes three clinical visits with in-office administration of the misoprostol and observation while passing the pregnancy. Ongoing medical research has refined the clinical regimen used to perform a medication abortion allowing for more flexibility in how the abortion is performed and in extending the gestational limits to 63 days LMP (aka nine weeks). In the widely used evidence-based regime 200mg mifepristone is followed by 800mcg misoprostol inserted vaginally 24-72 hours later. Instead of three visits the evidence-based regimen recommends two clinical visits with the patient using the misoprostol at home rather than in the healthcare facility. There is wide-spread agreement among clinicians and

researchers of the preference and scientific strength of the evidence-based regimen (American College of Obstetricians and Gynecologists, 2005; Stewart, Wells, Flinn, & Weitz, 2001)

Study Design

This small qualitative study was designed to identify means by which physicians in primary care practices who do not currently offer abortions learn about other women's health advances. Rather than look for an exhaustive list of possible sites of intervention, the study used open-ended qualitative interviews to get a 'general sense' of what might be the normal course of information flow for non-abortion health information to physicians. Once a commonality was identified in the interview, a literature search of the issue was conducted to locate additional support for the findings. Subsequent, those findings were compared to the state of information dissemination for abortion technologies and the text of the interviews regarding abortion-related issues. The goal was to locate potential opportunities for intervention to introduce medication abortion into non-abortion providing physicians' offices.

Study Location

Arkansas was selected as the study location because of its comparatively large population, 2.7 million, its low population ratio of abortion providers to reproductive age women (1.04), the high percentage of women living in counties without an abortion provider (78%), the small number of actual abortion providers (6), the existence of services within only two counties (97% of counties unserved), and the study investigator's familiarity with the health care environment. Other important Arkansas characteristics include: its location in the 'Bible Belt of America,' the large number of

providers still practicing in solo or small group practices—thus potentially representing greater physician decision-making autonomy regarding practice formation and patients served.

This study sought to collect data from providers within a underserved county. Based on the state's geography and other demographic factors, City A, population approximately 80,000 (U.S. Census, 2000) was selected to serve as the study location for the interviews to be performed for the study. To preserve confidentiality no additional information is provided about the study site city.

Study Subjects

Physicians providing primary care or ob/gyn care to women of reproductive age in City A served as the potential study population. Because Arkansas has a law that only physicians can perform abortions, this study excluding advance practice clinicians as study subjects.

Letters were sent to the 72 physicians practicing within the town limits of City A. These physicians were identified through the local telephone book. A breakdown by medical specialty is in Table 1. The letter introduced the study asking the physicians to contact a toll-free number is they were willing to be interviewed.

Table 1: Subspecialties of physicians practicing in City A

Specialty	**#'s**
Family Practice without Obstetrics	30
Family Practice with Obstetrics	8
Internal Medicine	24
Obstetrics and Gynecology	9
Gynecology Only	1
Total	**72**

Six physicians contacted the study about participating; five were successfully interviewed. All of the physicians interviewed were female. Three were family physicians without obstetrics and two were internists. None of the physicians saw pregnant patients for prenatal care nor performed deliveries. Each identified as a 'women's health provider,' although none currently perform abortions. Interviews with each physician were done in person. Demographic data on the subjects is provided in Table 2.

Table 2: Study subject demographics

Subject #	Sex	Race / Ethnicity	Medical Specialty	Completed Residency
Dr. #1	Female	White	Family Practice	2000
Dr. #2	Female	White	Family Practice	2001
Dr. #3	Female	Vietnamese	Internal Medicine	1998
Dr. #4	Female	African American	Family Practice	1990
Dr. #5	Female	White	Internal Medicine	1998

Study Interview

Each interviewee was allowed to control the direction of the discussion through an open-ended format. General themes were covered in each interview: scope of practice and practice arrangements, disciplinary turf divisions, and knowledge of women's health conditions. The goal of the interview was to allow the interviewee to determine the scope of women's health and to see where, if at all, abortion fit into that construction. Questions also sought to illicit from the physicians, where and how they learn about new technologies and how those new technologies are incorporated into their clinical practice. The interviews were audiotaped and then transcribed. Accuracy of the transcription was reviewed by the study investigator who compared the completed transcript with the audiotape content.

Data Analysis

Data from the transcribed tapes was analyzed using open coding. Codes were compiled to created themes which were used to guide future steps in the analytic process. Next steps in analysis included: 1) reviewing the available literature on topics identified through the first level of analysis, 2) rereading the interview transcripts to compare physician knowledge with abortion to knowledge of other aspects of women's health, 3) developing a theory for why promotion of medication abortion is different than the dissemination of other aspects of women's health, and 4) formulating recommendations for the promotion of medication abortion based on these conclusions.

Results

Two main themes were identified with regard to how knowledge about advances in non-abortion women's health was gained by the physicians. These included the role of the pharmaceutical company representatives (aka 'drug detailers') and direct-to-consumer advertising. Two specific case examples are presented. The first addresses the diagnosis and management of depression/anxiety in women and the second surrounds the request by patients for Orthotricyclen® as an oral contraceptive. By comparison to levels of knowledge about the full range of non-abortion women's health pharmaceuticals, abortion is absent from the portfolio of the interviewed physicians.

Interview Results

The Role of the Pharmaceutical Representatives

All interviewees were asked to reflect on what professional avenues they utilized to learn about advances in the field of women's health. Each of the providers commented

that professional periodicals and other educational activities were important but rarely tapped as sources of information. None of the interviewees regularly attended state or national professional society meetings. By comparison, all the providers were in agreement about the important role that the pharmaceutical companies play in educating providers about new advances in women's health. As the interviews demonstrate, the pharmaceutical representatives are extremely visible to the physicians. When asked about the extent of their presence in the physicians' offices, each doctor commented on how frequently the representatives visit them.

> 'Yeah, we see a ton of them.' (Dr. #1)
>
> 'There's been days we've had seven reps through our office. Every day there's at least two or three...And every day at lunch we have somebody giving us lunch.' (Dr. #2)
>
> "Yeah, they do...that.' (Dr. #3)
>
> 'Almost daily somebody comes by.' (Dr. #4)
>
> 'I'll bet I see two a day.' (Dr. #5)

These representatives are more than simply sales people. They are actually seen as a regular source of medical information as one physician succinctly puts it: 'The drug reps keep us updated.' Another interviewee explains further when she is asked how she stays up with changes in the field:

> 'It's very hard. The pharmaceutical reps coming around really do help. I know it's biased but they do keep us up on their medicines and they bring around the journals and the articles that, of course, favor their drug but – you know – they do kind of keep you on your toes.' (Dr. #2)

As the interviewees explain, access to the physicians is, in part, justified by the drug companies' provision of free samples. Each of the physicians commented on the importance of free samples in providing care, especially to indigent or underinsured patients.

> 'It's free samples and that's [sic] the side that we enjoy. We have a fair number of indigent patients and so the samples are very useful. And even for those people who – that have insurance coverage it's always good to give them the samples first and see how they do...So we appreciate the samples and because of that...Well, you know – it's a symbiotic relationship to some degree.' (Dr. #4)
>
> '[The drug representatives] actually are very good around here about as far as indigent patients and stuff that we really are able to get a lot of samples so patients don't have that much trouble getting their medications...They work with us really well on that.' (Dr. #1)
>
> '[Free samples are] helpful...I have some patients that are indigent. We have some ... in the Medicare population which struggle to pay for medicines it's real helpful...Some people just can't afford [medications] without samples.' (Dr. #2)

The physicians see their relationship between the drug companies in the light of advocacy for their patients, allowing them to better serve those in their practice with the greatest need: 'We're a poor community here and so I'll take the rich drug companies' samples to give to my patients that might not necessarily be able to afford it.' (Dr. #5)

A Successful Case of Provider Education: Depression and Anxiety Diagnosis and Treatment

The transcripts reveal that the issues of depression and anxiety in women had been successful "detailed" to the physicians in the study. All physicians were highly knowledgeable about both the need for diagnosis of depression/anxiety in women and how to treat these conditions with pharmaceuticals. All five physicians commented on the high rate of depression and anxiety among their female patients. All felt comfortable addressing the issue and treating the patients and additional psychological and psychiatric support was not sought. They used free samples as a method for introducing pharmaceutical management of these conditions to patients. The below excerpts from the

physicians' interviews demonstrate the extent to which depression/anxiety clinical management has been incorporated into routine primary care and how the physicians actively seek out the diagnosis and initiate treatment.

> 'And I guess my biggest [condition is] probably depression and anxiety with women...And there's a lot of them that you [sic] know that they've probably have some underlying depression but they're not ready to hear that so you go ahead and you – and to make sure to rule everything out you work all that out. And then when you can kind of show them that it's not this. 'You don't have this horrible disease, you don't have that.' They're kind of like, 'Oh, I guess you're kind of right. Maybe I do,' and then, you know, they'll go on something and feel a whole lot better then they'll wonder why they didn't do it a long time ago.' (Dr. #1)
>
> '[Depression is] probably the number one thing I'm seeing...I mean, they don't always come in saying,' I'm depressed.' But I really – I prescribe more antidepressants probably besides nasal steroids and antihistamines. Probably more antidepressants more than anything else – well and antibiotics. Because it just – in the women, especially in the 40's and 50's so many women are depressed. And I – I wish I had a nickel for every time I prescribed an antidepressant.' (Dr. #2)
>
> 'I bet I spend 50% of my time in counseling not necessarily depression but a lot of anxiety in dealing with social issues, probably as much as I do medicine, you know, fiddling with people's blood pressure medicines.' (Dr. #5)
>
> 'Probably if I look at my stat – at least 40% of my patients, adults, are depressed. I have a lot of depression or anxious.' (Dr. #4)
>
> 'Well, most complaint...[is] not really depression but anxious, tired, fatigue. Well, most of these patient – it's like they don't really want to see psychiatrist. ' (Dr. #3)

A Successful Case of Direct-to-Consumer Advertising: Orthotricyclen for Oral Contraceptive Use

The text of the interviews reveals patients put pressure on physicians for specific pharmaceuticals. When the physicians were discussing their patterns for caring patients

needing birth control, several physicians responded that patients came in requesting a particular brand of oral contraceptives by name:

> The marketing is tremendous...I'll ask them. Well, do you have a brand in mind? And then 90% of the time it's Orthotricyclen...They come in asking for it by name. (Dr. #5)
>
> The one that they all come in for is that Orthotricyclen because of that commercial ... with those three women. They come in, they know it by name. 'What about that – 'And some of them don't know it by name but they can describe the commercial. And I'm supposed to know it by name...I think that if it's on TV that somehow makes it better. Some of it is acne, yes. But I think, primarily, people – when they see beautiful women on TV saying, 'I'm on this pill.' Then they want some of that too. They want to identify with that. (Dr. #4)

The request for a specific brand contrasts with the drug choices made for the treatment of depression and anxiety. Although the physicians are treating more depression and anxiety that any other condition, the physicians do not comment that the patients are requesting a particular pharmaceutical. Rather free samples serve as a means to connect providers to a particular brand of pharmaceutical.

What About Abortion?

Data from the interview transcripts is revealing as to where abortion is seen within the spectrum of women's health. While the interviewees were incredibly knowledgeable of a full range of non-reproductive women's health topics including incontinence, female sexual dysfunction, and heart disease, as well as the mental health conditions discussed earlier, they were unfamiliar with new advances in reproductive health such as emergency contraception, urine-based testing for sexually transmitted infections, and abortion.

Specifically there was discomfort with discussing the topic of abortion. None of the providers offered abortion care nor had they considered offering medication abortion. Their patients did not regularly request abortion services but when they did, patients were referred to providers outside the city limits, although the interviewed physicians were unsure exactly were patients had to go and what services they could receive. Asking about where their patients go for an abortion illuminated the hands-off approach to knowledge about who actually performs abortions and where and how women access those services. Physician-to-physician referrals which are a normal part of medical practice are not in place for abortion services.

> "I had that happen last week [request for an abortion]...I gave her the number of somebody I knew in Fayetteville and I said – I didn't do a direct referral or anything like that. There's no one in [City A] that I know of that does that abortions. So she either has to go to Tulsa, Little Rock, or Fayetteville. (Dr. #2)
>
> 'But I've actually never had that come up [request for an abortion] since I've been in practice down here, so it would be one of those things I'd have to call around and find out.' (Dr. #1)

This indirect process of triage was very different from the patterns of care established for other health care needs where the treatment modalities were discussed with confidence and referral patterns were well articulated and established within the city limits. When asked about where they would send a patient who needed additional cardiac care services or breast care the names of specific physicians and facilities in town were easily given and supported with examples of how they care for patients.

When asked specifically about patient demand for mifepristone or RU486, none of the physicians interviewed in the Arkansas City A had had a patient ask about medication abortion. Their answers were short and to the point:

'I haven't had any here' (Dr. #1)

'I haven't had that.' (Dr. #2)

'When they come [for] abortion...they always think that they're going to do a D&C.' (Dr. #3)

'No! I don't have anybody asking about that.' (Dr. #4)

'You know, I've never had one.' (Dr. #5)

Further analysis of the transcripts, however, reveal that the lack of provision of abortion is the result of other factors as well as lack of knowledge. When Dr. #5 is asked what she would do if a patient asked her about medication abortion, she responded: 'I would probably refer them. Mine crosses almost a religious problem there [for me] as an individual.' (Dr. #5)

In the physician's office of Dr. #4, free copies of a pocketsize *New Testament* were offered to all patients. A large bible was prominence displayed on the waiting room table. Nothing about the physician's practice itself, i.e., the practice name, the hospital affiliation, indicated its religious orientation but religion was clearly central to the practice of medicine in that location. The interview with Dr. #4 references a deficit in spirituality as a cause of many of her patient's ill health. In addition she is emphatic about her unwillingness to refer for abortion services.

Even for those without individual opposition, concern about community response may affect the willingness to provide abortion. Dr. # 3 comments on the 'judges' in the town that she perceives would oppose the offering of abortion services even is all the physicians were doing it:

'I don't want to be the first one to do that...You know that there's a lot of judges here. I mean, it just like they don't – I mean, they don't even allow lottery ... the[re's] just really no gambling – nothing like that – abortion...And it's been for years and it's just nuts, you know....very conservative....I think probably the community would probably not support [the

> offering of mifepristone]. But I'm not sure...I'm not sure really anybody doing here. But I don't know. But – I don't know anybody really do it here because we refer out.' (Dr. #3)

Literature Support for Interview Findings

The Role of the Pharmaceutical Industry

The transcripts from the interviews highlighted the role that the pharmaceutical companies are playing in the dissemination of medical information regarding health care advances and in the generation of patient demand for new medications. These findings are supported by several recent studies on the growth of the pharmaceutical industry.

According to study from the Boston University School of Public Health, brand-name drug makers in the United States in 2000 employed more people in their marketing departments than in their research and development departments. The study found that the marketing departments of major drug companies increased by an additional 32,000 employees in 2000. These individuals were 'mainly' sales representatives who promote drugs to physicians and HMOs (The Henry J. Kaiser Family Foundation, 2001). Additional studies utilizing data collected by IMH Health, an independent consulting company, confirm that 80 percent of money spent on the promotion of prescription drugs is targeted in three areas: detailing to office-based and hospital-based physicians, free sampling and advertising in professional journals (Rosenthal, Berndt, Donohue, Frank, & Epstein, 2002). While dollars spent on advertising in professional journals decreased from 1996-2000, spending on the promotion of prescription drugs to office-based physicians, including the retail value of free samples, increased by nearly $5 billion (Rosenthal, Berndt, Donohue, Frank, & Epstein, 2002). Thirty-one percent of expenditures are for detailing to physician practices or hospitals and fifty percent are

spent on free samples (Frank, Berndt, Donohue, Epstein, & Rosenthal, 2002). Person accounts by physicians interviewed for this study confirm the presence of a growing number of pharmaceutical representatives in their offices

Research has found that detailing has an effect of increasing the use of the detailed product (Gonul, Carter, Petrova, & Srinivasan, 2001; Mizik & Jacobson, 2004; Narayanan, Desiraju, & Chintahunta, 2004). As a result of these changes in prescribing habits, the dollars spend on pharmaceutical detailing produce enormous returns for the industry. One study of drugs introduced after 1997 found that the average return for each dollar spend on detailing was $10.29 (as cited in Elliott, 2006:82).

The transcripts reveal a level of comfort and familiarity among the interviewed physicians in the diagnosis and treatment of depression and anxiety, in part due to the role of the pharmaceutical representatives. A review of the literature locates the role of the pharmaceutical companies more broadly in the construction and marketing of these health conditions. Until about ten years ago, depression and anxiety management were hidden and rarely discussed within the realm of women's health. Within medicine these conditions were the domain of psychiatry and outside of medicine they were treated by psychologists and counselors. Mental health advocates have worked to make visible the role of mental health in overall women's health. Their efforts have been complemented, and co-opted, by the pharmaceutical industry's effort to expand the market for their products by promoting prescription drugs as a solution to these mental health conditions.

In his controversial book, *The Anti-Depressant Era*, Healy (1997) argues that the pharmaceutical industry helped to convert unhappiness into a disease that should be treated with drugs rather than psychotherapy (Healy, 1997). Anxiety has also been the

site of the production of a social illness (Moynihan, Heath, & Henry, 2002). The notion that large numbers of people suffer from anxiety is created through the social production of a new disorder called "social phobia," which is sold by both the pharmaceutical industry and the physicians that prescribe the treatment pharmaceuticals (Cottle, 1999). Central to these effort was the incorporation of treatment of mental health conditions with pharmaceuticals into primary health care. According to data from Competitive Medial Reporting, spending on promotion of antidepressants to health care professions (i.e. detailing and free sampling) totaled $985 million, or 14.4 percent of all dollars spent in promotion of drugs to physicians (Rosenthal, Berndt, Donohue, Frank, & Epstein, 2002).

In addition to detailing its' medications directly to physicians, the pharmaceutical industry also attempts to create demand for its products by marketing drugs directly to the public, through a practice known as 'direct-to-consumer (DTC) advertising.'

DTC advertising dates back to the early 1980s when companies first began to market their products to the general public. In 1983, the Food and Drug Administration (FDA) imposed a moratorium on this marketing strategy but the ban was lifted in 1985, and since then, the industry has devoted increasing resources to this strategy (Hollon, 1999). In 1997, the FDA issued guidelines for the broadcast advertising of prescription drugs directly to consumers and as a result, annual spending on DTC advertising for prescription drugs tripled between 1996 and 2000, reaching nearly $2.5 billion (Rosenthal, Berndt, Donohue, Frank, & Epstein, 2002). Researchers working on the issue of direct-to-consumer (DTC) advertising have argued that patients' requests for medication are a powerful driver of physicians' prescribing decisions (Mintzes et al.,

2002; Zachry et al., 2002). The interviews with Arkansas primary care providers demonstrate the reach of this financial investment.

Because of the high price tag, DTC advertising has not been adopted as a marketing strategy for every pharmaceutical product. In 2000, the 20 prescription drugs for which spending on DTC advertising was greatest accounted for about 60 percent of the total industry spending on such advertising (Rosenthal, Berndt, Donohue, Frank, & Epstein, 2002). The two largest category of products for which this strategy is employed are nasal sprays, accounting for 11.6 percent, and antihistamines, 6.1 percent of all sales. The single most promoted drug, Vioxx®, had a DTC budget of $161 million dollars in 2000. Of drugs targeted specifically at women of reproductive age, only one product, the birth control pill Orthotricyclen®, makes the top 20 list, with 47 million dollars spend on DTC advertising in 2000 (ranked 17th in spending overall). Like other oral contraceptives this formulation helps to reduce acne. What is unique about the drug is that the company sought approval from the FDA specifically for this indication. As such, Orthotricyclen®, unlike other birth control pills, can advertise that it is 'the only birth control pill clinically proven to reduce mild to moderate acne.' The company has used this marketing advantage and made the decision to advertise extensively in both print and TV advertisements. In a recent report from the California HealthCare Foundation on the use and expenditures of prescription drugs in California in 1999, Orthotricyclen® ranked eleventh among all medications for percent growth, up 90.3 percent from 1998, to an annual sales of $49 million (Bymark & Waite, 2001). The experience of the interviewed Arkansas physicians helps explain this rise in sales.

The finding that there is a direct request for Orthotricyclen® and the lack of drug-specific patient demand for the treatment of depression and anxiety is provided support in the expenditures made by the industry in DTC marketing of anti-depressants. Only $32 million dollars, 0.5 percent of sales, was spent on DTC advertising of anti-depressants (Rosenthal, Berndt, Donohue, Frank, & Epstein, 2002). Thus the goal with depression and anxiety medications is to make the physician comfortable with a particular medication and to provide free samples to connect the patient to the drug, rather than to generate patient demand for a given medication as is the strategy with Orthotricyclen®

The Uniqueness of the Marketing and Sales of Mifepristone for Abortion

Mifepristone is sold under the trademark Mifeprex® in the United States. Mifeprex is produced and distributed in the US by Danco Laboratories, Inc (Danco). A brief history of mifespristone's approval in the US reveals how and why Danco does not behave as a 'normal' pharmaceutical company and thus the product is not known about to the extent that other non-abortion women's health advanced are known.

Mifepristone, known as "RU-486" in France, became available to French women in 1988. The pill immediately became entangled in international anti-abortion politics. During the presidency of George H.W. Bush, an import ban was imposed on mifepristone, thus precluding the ability to conduct clinical trials and seek approval for the drug in the US. On his first official day in office in 1992, newly elected president Bill Clinton lifted the import ban on mifepristone paving the way for clinical trials. Weary of anti-abortion activity in the US, the French manufacture was unwilling to undertake an effort to seek approval for mifepristone in the US. In 1993, President Clinton convinced Roussel Uclef, the French company holding the patent to RU486, to transfer US rights to

the drug to the Population Council, a nonprofit research and advocacy group in New York City (Ulmann, 2000). The Population Council and the Abortion Rights Mobilization quickly conducted clinical trials (Hilts, 1996) and in September 1996 the FDA gave tentative approval to mifepristone, essentially expressing satisfaction with the efficacy and safety of the drug. The remaining steps to approval centered on 'manufacturing and labeling issues' (Talbot, 1999). For this phase the Population Council needed a pharmaceutical company to become involved with the drug. Final approval of the drug by the FDA would not occur until September 2000.

The four-year gap between 'tentative' and 'final approval' was, in part, the result of the unwillingness on the part of any major US pharmaceutical firm to seek the commercial rights to offer this drug (Charo, 1991). Thus, the Population Council, which held the patent, was forced into a series of negotiations, some disastrous, with various would-be manufacturers and distributors (Talbot, 1999). It was commonly understood that the reluctance of regular drug companies to take on this drug stemmed from fears of antiabortion boycotts, and very possibly, violence (Lader, 1995). In the end, a new company, Danco Laboratories Inc., was formed with the sole purpose of producing and marketing mifepristone (Talbot, 1999).

Because Danco makes only a single drug it does not have the financial resources to engage in the types of activities routinely undertaken by drug companies to promote uptake of their products. Compounding the limitations resulting from being single product focused, the price of the drug further minimizing the profit margin for the company. The product's price is set to allow for competition with more traditional aspiration abortion. Research has found that the cost of aspiration abortion,

approximately $372 before 10 weeks (Henshaw & Finer, 2003), is artificially low in comparison to other non-abortion but medically similar procedures (Grimes, 1992). This price setting is the result of several factors. First, over three-quarters of abortions are paid for by women themselves (Henshaw & Finer, 2003). Because abortion services are most needed by women of lower economic means (Boonstra, Gold, Richards, & Finer, 2006), raising the cost of abortion who make it out of reach for the women who need it. Second, the abortion services community is intertwined with the feminist women's health movement that seeks to reduce the cost of health care for women (Joffe, Weitz, & Stacey, 2004). Third, the charge against abortion providers by their opponents that abortion providers seek a profit at the expense of women (Blanchard, 1994; Joffe, 1995) is countered by maintaining a low cost of care. This lack of a large profit potential precludes Danco from employing a pharmaceutical detailing work force.

In addition to lacking a detailing staff, the special circumstances of the FDA approval make the offering of free samples almost impossible (Joffe & Weitz, 2003). Unlike other medications for which a physician can write a prescription, this drug is not available routinely through pharmacies. Instead the drug must be ordered directly from the prescribing physicians and given by the physician to the patient. Before the physician can order the drug s/he must establish an account with Danco and sign a 'Prescriber's Agreement.' In this way the physician becomes part of a "list" of physicians who offer mifepristone. While this list is confidential and not accessible to abortion opponents, physicians are still highly hesitant to sign these agreements. As a result, even if Danco had a drug detailing workforce force, these individuals could not simply passively leave free samples. Instead they would need to convince the physician that s/he should sign up

to be a provider and sign the 'Prescriber's Agreement,' a difficult and labor intensive task.

Another complicating factor is that the drug, mifepristone, is used in combination with a second drug, misoprostol, which is produced by another drug company that has demonstrated hostility towards the promotion of the role of its drug plays in medication abortion. In 2000, around the time of mifepristone approval, the producer of misoprostol Searle Pharmaceuticals (which has sense been acquired by several other companies) issued a letter to all obstetrician gynecologists reminding them that Searle did not support the use of the drug misoprostol in pregnant women. Any effort to detail medication abortion would need to be able to detail both mifepristone and misoprostol. Therefore it would be up to the detailers for the first drug, mifepristone, to supply samples of the second drug, misoprostol, as well—a highly unusual circumstance. Whether the company would have right to conduct such secondary marketing is also a question to be answered.

The last complicating factor in detailing is the regime used for medication abortion itself. Pharmaceutical companies are only allowed to detail a drug as it is approved for use by the FDA. As described earlier in the paper in the section on "Primer on Medication Abortion," the preferred treatment regime is substantially different from the regimen approved by the FDA. The evidence-based regimen involves less use of the mifepristone drug from 3 pills to one pill of mifespritone. This change reducing costs of the medication by almost $180. The evidence-based regimen calls for only two visits instead of three. Finally the evidence-based regimen raises the efficacy of the treatment from 95 to 98 percent. Thus is the company were to detail mifepristone use it would have

to detail a more expensive, more medically complicated, and less efficacious regimen, a potential deterrent to new uses who might be willing to adopt the more streamlined evidence-based regimen.

DTC Advertising as a Barrier for Dissemination to Physicians

The enormous success of Orthotricyclen®demonstrates that with enough resources it is possible to influence women's desire for a given pharmaceutical product and have it effect a physician's prescribing behavior. By comparison decisions made regarding DTC advertising for medication abortion may be inhibiting the expansion of services rather than facilitating its dissemination into primary care. In 2000 after the approval of mifepristone, the National Abortion Federation (NAF) received financial support from several foundations to conduct an ad campaign for the medication abortion option. A print ad was designed with standard marketing techniques, i.e. the look of the woman, the lighting, etc. The ad was run in over a dozen women's magazines including *Self, Glamour*, and *Vanity Fair*. There are two major differences, however, between regular DTC advertisement and the DTC advertising for medication abortion. First, the DTC is being conducted by a third party, not the drug company. As such, it is not obligated to include all the language on side-effects, etc. It is unclear what affect this difference might have on women.

More importantly, the second difference is that unlike the ads for Orthotricyclen® and other DTC advertised products, the NAF sponsored ad does not refer the patient to her physician but rather only to a toll-free hot line. The ad states "Find out if the Early Option Pill is an option for you 1-800-772-9100 www.earlyoptions.org." When a woman calls the hotline, a counselor directs her to the closest abortion provider in her area who is

a member of the National Abortion Federation (NAF), the professional organizations of abortion providers. The woman is not encouraged to ask her primary care provider for the drug and should a physician in the area who is not a member of the NAF be providing medication abortions, the woman would not be informed of that resource. It is unlikely that primary care physicians who offer limited abortion services would be a member of NAF since membership is both expensive and cumbersome, as practices are asked to meet certain quality standards and to consent to clinical site visits from NAF. Thus even if the woman's own doctor provided abortion care of which she was unaware, the woman would not be directed to that physician for care.

While a toll-free referral service is invaluable to women, especially in states like Arkansas where access to unbiased information is difficult to receive it may have unintended consequences for the diffusion of this new abortion technology. One goal of DTC advertising is to produce pressure on physicians to become aware of and offer medications that patients are requesting. When abortion patients seek information from the hotline and are not encouraged to discuss the option with their providers, no such demand is generated. This bypass may create the illusion for providers that their patients are not in need of such services and as a result a routine actor in the chain of activities geared at stimulating provider familiarity with a medication may be eliminated. In addition, providers who may themselves be recipients of the advertisements as consumers of mainstream magazines may not see themselves as within the chain of abortion service provision.

As expected the lack of a marketing sales force, access to free sampling, and a DTC advertising campaign involving the physicians has resulted in low demand for

medication abortion, with none of the physicians having experienced a patient asking for the "abortion pill."

Discussion: Implications for the dissemination of advances in abortion care

Currently only a limited number of abortion care is offered in private physician's offices Increasing the number of private physicians who perform abortions in these settings could have a positive effect on access to abortion, especially in underserved areas. This study points to the importance of the pharmaceutical companies in the dissemination and promotion of new technologies and advancements in women's health to these private physicians. Abortion, to date, is not part of this routine chain of information dissemination. Rosenthal et al (2002:502) explain the implications of this exclusion: 'physicians are unlikely to prescribe a drug unless they are familiar with it and are comfortable prescribing it'.

Efforts to promote medication abortion should consider adopting the one-to-one marketing technique used by the pharmaceutical industry to reach office-based physicians. Systems-based solutions to providing free samples of both mifepristone and misoprostol should be developed so that providers can be encouraged to offer the medications should women ask about abortion. The onsite availability of the drug may encourage a provider to initiate abortion services. DTC advertising should be expanded and include the encouragement of women to talk with their physicians about medication abortion. Advocacy must be undertaken to educate both women and physicians about this new advancement in abortion technology.

The target audience for the drug detailing and free sampling must be broadly defined. Historically, abortion has been seen as within the discipline of obstetrics and

gynecology but as the interviewees in Arkansas demonstrate, the boundaries of 'women's health' are undefined and fluid. Physicians from the specialties of family practice, internal medicine, pediatrics, surgery, as well as obstetrics and gynecology claim the identity of 'women's health provider.' Efforts must be undertaken to incorporate abortion as a routine component of the clinical practice of women's health, broadly defined. In this way the greatest potential number of new providers will be created.

The interviewees in this study suggest that depression/anxiety are 'coming out of the closet.' Abortion care proponents should examine the relationships built between mental health advocates and the pharmaceutical industry to better understand the production and mainstreaming of depression and anxiety into women's health.

Limitations of this approach

The suggestion to utilize standard drug company techniques to sell medication abortion along with other advances in women's health is not without limitations. Such an approach does not guarantee that abortion will be adopted as easily as other advances have been. Certainly abortion is far more politically and emotionally charged than other aspects of women's health, as the interviews reveal.

However, a review of the history of abortion provides some reason for optimism. Scholars of abortion history have documented the role of physicians in pushing for abortion reform, in part because of the horrific experience of illegal abortion for the women they were caring for in their hospitals as well as the desperation they were encountering in their patients who were asking for assistance in seeking out illegal services (Joffe, 1995). As abortion becomes less accessible as a result of continuing decline in the number of abortion providers, it may be possible to convert compassion for

patients into actual services among primary care providers even in areas where abortion is contentious. Primary care providers in these areas may be willing to offer abortions to patients with which they have established relationships, where there is greater understanding of the life circumstances that surround the decision to abort. They may be willing to consider making the decision on patient-by-patient basis, similar to how physicians made decisions regarding the provision of 'illegal' abortions prior to Roe (Reagan, 1997).

Conclusions

Abortion services are now provided by approximately two thousand total clinical facilities nationally which are concentrated in urban centers. Many of these clinics are specialty abortion services and are isolated from full-scope health care systems (AGI, 2001). As a result of this specialization of the care delivery of services, abortion, while remaining legal, has become increasingly inaccessible to many American women. Arkansas is a state where women in need of abortion services are significantly underserved.

The FDA approval of mifepristone (known as RU486 in France) in September 2000 has created an opportunity to introduce abortion as a routine component of women's health primary care within the traditional office practice setting, thereby expanding access to abortion in underserved areas. This form of abortion differs substantially from surgical abortion in that it does not require specialty training nor does it require the physician to perform anything invasive. However, primary care providers are unaware of advances in abortion technologies.

This study demonstrates that the pharmaceutical industry is a regular source of information for primary care providers in non-urban settings and that free samples are used to maintain access to physicians. Formerly taboo issues such as depression and anxiety in women are now routinely integrated into care with physicians introducing the diagnosis to patients. Free samples which are provided by the companies help patients accept treatment. For other health care concerns, DTC advertising also plays a role in generating patient demand, which puts pressure on the physicians to modify their prescribing behavior. The interviewees in this study note the patient demand for Orthotricyclen®, the only woman-specific drug on the top 20 list of DTC products.

Efforts should be undertaken to disseminate information on medication abortion using standard drug company techniques including: drug detailing, provision of free samples, and direct-to-consumer advertising. While these activities will certainly be complicated by the polemic aspects of the abortion debate, success with mainstreaming other taboo subjects such as depression afford some optimism to the work. In addition, the history of abortion demonstrates that when physicians are confronted with the real needs of their patient populations, they may chose to act in ways outside their established boundaries.

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CHAPTER 14: SUBMITTED ARTICLE

OPINIONS AND USE OF MEDICATION ABORTION AMONG CALIFORNIA'S RURAL PRIMARY CARE PROVIDERS: THE RESULTS OF AN ACADEMIC DETAILING INTERVENTION PROJECT*

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Abstract

This paper discusses the results of a project that used an innovative provider education approach known as "academic detailing" to facilitate the diffusion of medication abortion using mifespristone (aka RU486 in France and commonly as the "abortion pill"). Physicians practicing in eight rural California counties (n=1428) were asked to complete baseline and follow-up surveys. Between the two surveys, clinician educators visited a random sample of physicians (n=218) to conduct a six-month academic detailing intervention disseminating standardized tiered messages and materials related to medication abortion. This paper reports the findings from the baseline survey related to opinions about abortion in general and medication abortion specifically as well as the results of the academic detailing intervention. Statistically significant changes in physicians' willingness to provide medication abortion were found for physicians who received academic detailing. However, the process was labor intensive with large numbers of practice visits and very short face-to-face interaction periods.

Opinions and Use of Medication Abortion among California's Rural Primary Care Providers: The results of an academic detailing intervention project

Introduction

In September 2000, the U.S. Food and Drug Administration (FDA) approved mifepristone (known as RU486 in France and commonly called the "abortion pill") for distribution and use as medication abortion in the United States.[1] Advocates heralded mifepristone's potential to reverse declining abortion access because of its potential use in private physicians' offices. This paper discusses the results of a project that used an innovative provider education approach known as "academic detailing" to facilitate the diffusion of medication abortion knowledge and provision among primary care physicians in practice in rural California. In this study, we found low knowledge and provision of mifepristone prior to the intervention. We also identified widespread support for legal abortion and surprising changes in physicians' willingness to provide medication abortion after receiving academic detailing. The majority of those physicians who received academic detailing visits found the information and visits useful. These findings suggest that academic detailing may be one way to increase awareness and potential use of mifepristone for medication abortion. The process itself, however, was labor intensive with large numbers of practice visits with very short face-to-face interaction periods. Recommendations for future replication are highlighted.

[1]The phrase "medication abortion" is used to refer to abortions involving pharmaceuticals as advocated by Weitz et al (2004). The phrase "medical abortion" is also used to refer to abortions using mifepristone.

Background

Abortion Provision in the United States and California

In 2000, only 1,819 locations in the United States reported offering abortion care. One quarter of all these facilities are specialized abortion clinics, defined as those where at least half of patient visits are for abortion. Such clinics provided 71 percent of U.S. abortions in 2000. Most of the facilities that offer abortion care are located in large urban areas, leaving 86 percent of all U.S. counties without an identified abortion provider; and representing a decline of 37 percent since 1982 (Finer & Henshaw, 2003). The status of abortion care in California is less bleak than in other parts of the U.S., but is still problematic for women in many parts of the state. Between 1982 and 2000, the number of abortion providers in the state declined from 583 to 400. As in other parts of the country, large specialty clinics located predominately in urban centers provide the bulk of the abortion care and 41 percent of the state's 58 counties are without a known abortion provider (Finer & Henshaw, 2003). As a result, women living in rural communities in California face substantial barriers to accessing care.

Abortion Provision with Medication Abortion

Medication abortion was thought to be one potential solution to the declining number of abortion providers. Medication abortions use pharmaceutical agents to induce a miscarriage in a pregnant woman. In September 2000 the FDA approved mifepristone under the trade name Mifeprex®, produced by Danco Laboratories, for use in medication abortion in the U.S. To induce a medication abortion a pregnant women initially takes the mifepristone and subsequently follows it with use of a second drug, misoprostol, a generic prostaglandin. Differing mifepristone/misoprostol regimens are used by

providers in the United States.[2] All regimens have been found to be at least 95 percent effective.

Early surveys exploring whether physicians not currently offering abortion care would consider providing medication abortion once approved by the FDA were highly encouraging. In 1991 a survey of California obstetricians and gynecologists reported that 32 percent of responding physicians not currently performing abortions would do so using RU486 (Heilig, 1992). A study conducted in rural Idaho in 1994 found that 26 percent of respondents would consider prescribing RU486 if it became available (Rosenblatt, Mattis, & Hart, 1995). A survey of members of the Society for Adolescent Medicine in 1996 reported that if RU486 were FDA-approved, 42 percent of the responding physicians would prescribe it (Miller, Miller, & Pinkston Koenigs, 1998). Finally, in 2000 (one year prior to FDA approval) The Henry J. Kaiser Family Foundation (KFF) reported that one in three gynecologists not currently providing abortion care said they would offer the drug once approved. In addition, 31 percent of family practice physicians said that they too would offer the drug (The Henry J. Kaiser Family Foundation, 2000).

Data from the first years of mifepristone use in the U.S. suggest that the diffusion of mifepristone is occurring. Since the FDA approval of Mifeprex® an estimated 460,000

[2] The FDA labeling for Mifeprex® recommends use in women who are less than 49 days from their last menstrual period (LMP) and involves 600mg of mifepristone followed 48 hours later by 400mcg misoprostol taken orally. Care includes three clinical visits with in-office administration of the misoprostol and observation while passing the pregnancy. Ongoing medical research has refined the clinical regimen used to perform a medication abortion allowing for more flexibility in how the abortion is performed and in extending the gestational limits to 63 days LMP. In the accepted evidence-based regime 200mg mifepristone is followed by 800mcg misoprostol inserted vaginally 24-72 hours later. Instead of three visits the evidence-based regimen recommends two clinical visits with the patient using the misoprostol at home rather than in the healthcare facility. There is wide-spread agreement among clinicians and researchers of the preference and scientific strength of the evidence-based regimen (American College of Obstetricians and Gynecologists, 2005; Stewart, Wells, Flinn, & Weitz, 2001).

women in the United States have used the abortion pill (Danco Laboratories, 2005). In the first half of 2001, an estimated 600 clinicians used the method (The Alan Guttmacher Institute, 2005). In 2001, the National Abortion Federation reported that 50 percent of its members were offering mifepristone (as reported in The Henry J. Kaiser Family Foundation, 2001a). As of 2005, 246 Planned Parenthood Federation of America centers offered medication abortion, including in 84 sites that do not also offer the more traditional aspiration (aka "surgical) abortion (Fjerstad, 2006).

Experts disagree as to how to assess the pace of adoption of this new technology among physicians not previously offering abortion care. A KFF survey of physicians conducted one year after the approval of mifepristone found that only six percent of gynecologists and one percent of general practice physicians had offered mifepristone since approval (The Henry J. Kaiser Family Foundation, 2001b). Observers in the mainstream media argue that the slow uptake among non-abortion providing physicians raises concerns about mifepristone's true ability to increase abortion access (Basinger, 2001; Gellene, 2001; Kolata, 2002; Nemecek, 2000; Russell, 2001). Abortion rights advocates counter that integration of this technology into clinical practice is following a normal course which, regardless of the technology itself, is always a slow and step-wise process (Stewart as quoted in Rubin, 2001; Saporta as quoted in Russell, 2001). They look to the experience in Europe where it has taken over a decade to gain widespread use (Jones & Henshaw, 2002).

Regardless of the outcome of this debate both groups agree that efforts are needed to promote the diffusion of medication abortion among non-abortion providing physicians. Unfortunately, while several scholars have sought to understand the political

and social history as well as the meaning of mifepristone (Brodie, 2002; Charo, 1991; Clarke & Montini, 1993; Joffe & Weitz, 2003), little research exists on actual efforts to promote its uptake within the non-abortion providing physician community.

A few studies examine physician willingness to provide mifepristone offer some limited guidance to the design of an intervention focused on increasing use of mifepristone by physicians not currently offering abortions. Coeytaux, Moore, and Gelberg (2003) surveyed 20 women's health providers in California to understand what would be required to begin offering new services. They recommend getting information to the generalists and improving access to training for primary care providers. In their analysis of the KFF 2001 data, Seelig, Gelberg, Tavrow, Lee, and Rubenstein (2006) advocate for two types of intervention. For precontemplation-stage physicians, they recommend designing programs that emphasize clinical benefits and feasibility and for contemplation-stage physicians, assistance overcoming barriers associated with FDA regulations and concerns about violence and protests.[3]

Conceptual Framework for Promoting Diffusion of Medication Abortion Using Academic detailing

The question of how to promote the uptake of new technologies within the field of medicine continues to challenge organizational and diffusion theorists. For the adoption of mifepristone to redress the declining availability of abortion care, two barriers must be overcome. First, providers must begin offering abortion services. Second, they must adopt a relatively new technology as the means for that abortion provision. In this way,

[3]These stages reference Prochaska and Di Clemente's Transtheoretical Model that elaborates four stages of change: precontemplation, contemplation, action, and maintenance (Prochaska, DiClemente, & Norcross, 1992).

the challenge to mifepristone diffusion is more complex than the simple diffusion of a new pharmaceutical, which often involves substitution of drug A for drug B rather than adoption of an entirely new service.

A body of scholarship, emerging primarily from the economic and business literature, attempts to explain and predict the diffusion of new products (see Mahajan, Muller, & Wind, 2000). Many of these models build from Everett Rogers' (1962) original work (now in its fifth edition (2003)) in which he defines diffusion as a process by which an innovation is communicated through certain channels over time among members of a social system. Rogers argues that the process follows an "S"-shaped curve through five categories of adopters: innovators, early adopters, early majority, late majority, and laggards. The innovation-decision process goes through five stages: knowledge, persuasion, decision, implementation, and confirmation. In his theory, Rogers argues that there are five attributes of innovations that affect adoption of new technologies: relative advantage, compatibility, complexity, triability and observability. Important to this discussion is the role of compatibility, which is defined as the degree to which an innovation is perceived as consistent with existing values, past experience, or needs.

The impetus for diffusion in health care is often thought to stem from a technological imperative that drives modern society in general (see Woodward, 1965), and health care specifically (Wolf & Berle, 1981). Such a vision, however, ignores the reality that the pace of technological diffusion in health care is often slow and highly resisted (Coye, Aubry, & Yu, 2003) with a much longer diffusion curve than seen in other sectors of the economy (Stepnick & Findlay, 2003).

Fennell and Warnecke (1988) argue that one reason for the slow adoption of new innovations in health care is that the model for diffusion in this field is rigid and does not facilitate change. The traditional diffusion model in health and medicine relies on several assumptions—that knowledge flows from the scientist to the practitioner via medical journals, professional meetings, and/or contact with other professionals. Systematic reviews of interventions seeking to change provider behavior conclude that these passive approaches are generally ineffective and unlikely to result in behavior change (Grimshaw et al., 2001), and that common information-only strategies demonstrate little to no change in behavior when used alone (Davis, Thomson, Oxman, & Haynes, 1992; Granados et al., 1997; Oxman, Thomson, Davis, & Haynes, 1995).

One intervention strategy that has been well tested and shown some limited positive results in changing physician behavior is the use of face-to-face outreach with physicians, a technique known as "academic detailing." The goal is to succinctly present information using graphic and written materials that reference authoritative and unbiased sources of information (Fender et al., 1999). One assumption of this technique is that person-to-person contact with credible experts who provide structured alternatives is necessary to overcome the underlying motivations for the current behavior, such as strongly held beliefs about what care is best and patient demand for a particular drug or treatment (Soumerai, 1998).

The idea that face-to-face contact can affect the diffusion of health care technology was first demonstrated by Coleman, Katz, and Menzel (1966) in their sentinel study which identified the role of "detailmen" in promoting adoption of a new healthcare innovation. Pharmaceutical companies continue to focus on this strategy as a means to

promote the uptake of new products. In 1998, the pharmaceutical industry spent almost $13 billion promoting products in the U.S. Fifty-two percent of these expenditures were for free drug samples provided to physicians with an additional 28 percent spent directly on office promotion (Ma, Stafford, Cockburn, & Finkelstein, 2003). Research has demonstrated that this promotion strategy and the availability of free samples changes physician prescribing behavior (Abramson, 2004; Chew et al., 2000; Goodman, 2001).

When the techniques of pharmaceutical detailing are undertaken by a financially unconnected organization, often a university of public institution, the practice is called "academic detailing." Credited with the development of academic detailing, Soumerai and Avorn first tested this model in the early 1980s to address the high clinical and economic costs of improper drug utilization (Soumerai & Avorn, 1984) and later to improve the appropriateness of blood product utilization in hospitals (Soumerai et al., 1993) and psychoactive drugs in nursing homes (Avorn et al., 1992). All studies found positive results for academic detailing.

In their work, Avorn and Soumerai identified the importance of follow-up visits for positively reinforcing clinicians' successful experiences implementing the recommendations made in the initial visits. In addition, the reinforcement visits also provide the opportunity to identity and surmount individual barriers to recommended practice (Soumerai, 1998). In their original study, Soumerai and Avorn (1987) found that those clinicians who received a second "reinforcement visit" reduced prescribing of study medications twice as much as those receiving only one visit. Interestingly, in their study, total exposure time was not associated with the degree of behavior-change suggesting that a brief reinforcement visit was more important that longer single visit.

Based on their experience with academic detailing and a review of the pharmaceutical detailing literature, Soumerai and Avorn (1990) outlined the eight principles for successful academic detailing:

1) Conduct interviews to investigate the baseline knowledge and motivations for current prescribing patterns among the target audience;
2) Focus programs on specific categories of physicians, as well as their opinion leaders;
3) Define clear educational and behavioral objectives for the planned intervention;
4) Establish credibility by associating with a respected organizational identity, referencing authoritative and unbiased sources of information, and presenting both sides of controversial issues;
5) Actively engage physician participation in the educational interactions;
6) Use concise, graphic educational materials;
7) Highlight and repeat the essential messages; and
8) Provide positive reinforcement of improved practices in follow-up visits.

In 1997, the Cochrane Collaboration commissioned a systematic review of the existing evidence regarding the use of academic detailing visits to effect professional practice and health care and concluded that educational outreach visits, particularly when combined with social marketing, appear to be a promising approach to modifying health professional behaviors, especially prescribing (Thomson O'Brien et al., 1997).[4] Since the

[4] Using its standardized methodology, the Cochrane reviewers selected only randomized trials of outreach visits identified during a search of multiple data sources. Eighteen studies met the criteria and were included in the review (Avorn & Soumerai, 1983; Avorn et al., 1992; Berings, Blondeel, & H., 1994; Cockburn et al., 1992; de Burgh et al., 1995; Dietrich et al., 1992; Diwan et al., 1995; Feder et al., 1995; Newton-Syms et al., 1992; Putnam & Curry, 1985; Rabin et al., 1994; Raisch, Bootman, Larson, &

Cochrane review, numerous other academic detailing efforts have been undertaken for a range of health issues. Both randomized and non-randomized studies have documented positive as well as neutral or mixed results.[5] Unfortunately, despite the large number of trials of the technique, there is no standard methodology for conducting or measuring the effectiveness of academic detailing. Despite these limitations, reviews in the literature continue to recommend academic detailing as a means of implementing change (see Gross & Pujat, 2001; Sbarbaro, 2001; Sweet & Patel, 1996).

McGhan, 1990; Ross-Degnan et al., 1996; Santoso, Suryawti, & Prawaitasari, 1996; Soumerai et al., 1993; Steele, Bess, Franse, & Graber, 1989; Stergachis, Fors, Wagner, Sims, & Penna, 1987; Yeo et al., 1994). Six additional studies were excluded (Ray, Blazer, Schaffner, & Federspiel, 1987; Ray, Blazer, Schaffner, Federspiel, & Fink, 1986; Ray, Schaffner, & Federspiel, 1985; Ray et al., 1993; Ross-Degnan et al., 1996; Schaffner, Ray, Federspiel, & Miller, 1983).

[5] The purpose of the intervention is varied, including:

- prescribing patterns (Alvarez & Gutierrez, 2001; Avorn, 1992; Barreuther, 1997; Beier, 1993; Boothby, Wang, Mayhew, & Chestnutt, 2003; Braybrook & Walker, 1996; Dole & Murvin, 2003; Dolovich, Levine, Tarajos, & Duku, 1999; Gonzales, Steiner, Lum, & Barrett, 1999; Gurwitz, Soumerai, & Avorn, 1990; Ilett et al., 2000; May, Rowett, Gilbert, McNeece, & Hurley, 1999; Meador, Taylor, Thapa, Fought, & Ray, 1997; Peterson, Bergin, Nelson, & Stanton, 1996; Peterson, Stanton, Bergin, & Chapman, 1997; Peterson & Sugden, 1995; Reeve, Peterson, Rumble, & Jaffrey, 1999; Richards, Toop, & Graham, 2003; Solomon et al., 2001; van Eijk, Avorn, Porsius, & de Boer, 2001; van Eijk, Belitser, Porsius, & de Boer, 2002; Zwar, Wolk, Gordon, & Sanson-Fisher, 2000)
- management of specific medical conditions (Baran et al., 1996; Blackstien-Hirsch, Anderson, Cicutto, McIvor, & Norton, 2000; Cohn, Wingard, Patterson, McPhee, & Gerbert, 2002; Denton, Smith, Faust, & Holmboe, 2001; Fender et al., 1999; Lin, Simon, Katzelnick, & Pearson, 2001; Pond, Mant, Kehoe, Hewitt, & Brodaty, 1994; Reeder et al., 1994; Rosser, 2001; Rost, Nutting, Smith, & Werner, 2000; Tomson, Hasselstrom, Tomson, & Aberg, 1997; Turner, Parfrey, Ryan, Miller, & Brown, 2000)
- counseling regarding high risk behaviors (Goldstein et al., 2003; Gomel, Saunders, Burns, Hardcastle, & Sumich, 1994; Gomel, Wutzke, Hardcastle, Lapsley, & Reznik, 1998; Hansen, Olivarius, Beich, & Barfod, 1999; Swartz, Cowan, DePue, & Goldstein, 2002)
- cancer prevention education, counseling, and screening (Beilby & Silagy, 1997; Daly et al., 1993; Schroy et al., 1999; Sheinfeld Gorin et al., 2000; Williams, Eckert, Epstein, Mourad, & Helmick, 1994)
- clinical practice guidelines (Benincasa et al., 1996; Brown et al., 2000; Goldberg et al., 2001; Goldberg et al., 1998; Horowitz et al., 1996; Kim et al., 1999; Klein et al., 2003; Lin et al., 1997; Noirot et al., 2002; Ofman et al., 2003; Patel & Perez, 2001)
- and general medical issues such as evidence-based medicine concepts (Markey & Schattner, 2001); universal precautions (Mukti et al., 2000; Treloar, Higginbotham, Malcolm, Sutherland, & Berenger, 1996), journal reading selection (Stevermer, Chambliss, & Hoekzema, 1999), and compliance with the laboratory guidelines (Eckhart & Mathahs, 2001)

Academic Detailing of Medication Abortion in Rural California

Study Purpose

In this article, we report selected findings from the study *Promoting Comprehensive Healthcare in California Communities*. The purpose of this pre-intervention/post-intervention study was to assess the effectiveness, acceptability, and feasibility of academic detailing to inform primary care physicians in rural California about advances in reproductive health. The intervention focused on three underutilized reproductive health technologies: emergency contraception, medication abortion, and manual vacuum/uterine aspiration (MVA/MUA). In addition, information was also included about the Family PACT program, California's family planning program for low-income residents. The study was approved by the University of California, San Francisco's Institutional Review Board (IRB). This article reports the study findings related to medication abortion only.

Methods

Promoting Comprehensive Healthcare in California Communities included four main research components: 1) a needs assessment to select appropriate geographic and physician recruitment targets; 2) a baseline survey of physicians' knowledge, attitudes, and practices related to the detailed technologies; 3) a provider-level educational intervention using academic detailing; and 4) a follow up survey similar to the baseline. Comparative analysis of the baseline and follow up surveys assessed changes in physicians' knowledge, attitudes and practices with regard to the detailed products. The overall study design and subject participation is presented in Figure 1.

[Figure 1 about here]

Needs Assessment

Geographic Community Selection

County lines served as boundaries for our study communities. Using the data gathered from a review of publicly-advertised abortion providers in California counties and from the 2000 U.S. Census, a series of criteria were applied to select study counties that have a significant population of rural, low-income, and underserved women with limited access to abortion care. To be eligible for the study counties needed to have: 1) 0-1 publicly advertised abortion providers, 2) >25,000 rural inhabitants, 3) >25 people/square mile, and 4) >10% families living in poverty. Eight eligible counties were selected to reflect both geographic distribution and feasibility: three in the north, three in the central valley, and two in the southern central valley. Counties with similar numbers of primary care physicians and those in different regions were matched together. Four counties were assigned as intervention counties and four were assigned as control counties. To protect the confidentiality of our subjects, the study counties are not revealed in this paper.

Physician Selection

Primary care physicians practicing in one of the eight selected counties comprised the target population. For the purposes of this project, primary care physicians included those licensed in obstetrics and gynecology, internal medicine, family medicine and general medicine. Using data from the American Medical Association (AMA) database (updated in May 2004) 1,428 physicians licensed in the selected medical disciplines were identified in the eight study counties (688 physicians in the intervention counties and 741 in the control counties). In May and June of 2004, using business phone numbers from

the AMA database, county telephone phone books or the internet, study staff made screening calls to the physicians' practices to determine if they served women of reproductive age. Practices that responded "no" to the question "Does this practice serve women between the ages of 15-44?" were excluded from the study (n=10). An additional 245 physicians were excluded because their phone number could not be located, their phone was disconnected, it was determined that they had retired or died, or they were not able to be contacted after multiple (three) attempts. In total, 433 eligible physicians remained. To facilitate the examination of the effects of networks within counties, we chose to randomly assign physicians within the intervention counties to receive academic detailing. Using a random number generator, 50% of these physicians (n=218) were assigned to a case group and 50% were assigned to a control group (n=215).

Baseline and Follow-Up Surveys

The baseline and follow-up surveys were designed to assess physicians' knowledge, attitudes, and practices regarding medication abortion, emergency contraception, MVA/MUA, and the Family PACT program. The survey also asked providers to answer general questions about their opinions related to abortion Several questions mirrored those asked in national surveys administered previously by the Gallup Organization and KFF (The Henry J. Kaiser Family Foundation, 2001b)

Intervention

After administration of the baseline survey, all case physicians (n=218) were sent a letter that explained the goals and procedures of the academic detailing intervention and included a stamped, self-addressed "decline to participate" postcard. Twenty-four (11%) of the physicians in the intervention group chose to opt out of the study.

The academic detailing of the remaining 194 physicians began in late June 2004 and ended six months later in December 2004. The intervention was designed to meet the eight criteria for successful academic detailing as outlined by Soumerai and Avorn (1990) and described earlier. The one variance from the recommendations of other academic detailing studies surrounded the selection of the individuals to conduct the academic detailing. The specialized nature of medication abortion required rejection of Soumerai and Avron's recommendation that clinical pharmacists be used to conduct academic detailing. Because the FDA requires that physicians dispense the drug directly to patients, pharmacists currently play no role in medication abortion. Additionally since most of the issues surrounding provision are clinical rather that pharmaceutical, the study prioritized the use of clinicians with knowledge and experience providing medication abortion. Two specially-trained clinician educators (one family nurse practitioner and one certified nurse midwife) conducted the detailing visits.

Visit Protocol

The clinician educators visited or attempted to visit the practice of each physician who did not opt out of the study at least once and as many as five times. When presenting to a practice, the clinician educators identified themselves as employees of the University of California, San Francisco. At each visit, they attempted to meet with the intervention physician and engage him/her in a discussion of the detailed products using a hierarchy of messages. The clinician educators attempted to return to each physician until all the tiered messages were delivered or until the physician no longer desired additional information.

Key Messages and Materials

To control for variation in interpersonal interaction between the physicians and the clinician educators, key messages and materials were standardized and tiered for each product. Product-specific messages were presented in the context of an overall "meta-message" that incorporating these products would promote continuity of care. Written materials were provided to accompany each of the messages. Materials were distributed in professional, attractive glossy folders with the names of the project and of UCSF.

Tier One messages for medication abortion focused on the scientific mechanism of action and stressed the safety and efficacy of the product, as well as the ability of the patient to use it as soon as she knows she is pregnant (at the time she misses her menstrual period). The clinician educators also told the providers that, in California, Medi-Cal (the state Medicaid program) and most private insurers pay for medication abortion at rates sufficient to cover the cost of providing the care. All physicians received a copy of a brochure entitled "What Your Colleagues are saying about Mifeprex®," produced by Danco Laboratories, Inc., in the Tier One information packet.

Tier Two messages for medication abortion included the ease of incorporating the new service into the providers' existing practice, along with specific guidelines for providing the evidence-based regimen (see Note 2). The Tier Two information packets included copies of five publications related to these themes (Association of Reproductive Health Professionals, 2003; Hausknecht, 2003; Prine, Lesnewski, Berley, & Gold, 2003; Stewart, Wells, Flinn, & Weitz, 2001; The Access Project, 2004).

In Tier Three, clinician educators stressed practical information physicians might need to begin offering medication abortion services. Central to this tier was the idea that

starting the service was feasible. Sample protocols and guidelines for administrative and clinical processes were provided. Since other research has demonstrated the value of free samples to physicians, the Tier Three intervention also offered physicians reimbursement for their first purchased supply of Mifeprex®(approximately $280). Lastly, the physicians were informed of training and technical assistance opportunities available through other sources such as the National Abortion Federation. Detailed physicians also received a card with the toll-free number of a physician-staffed twenty-four hour consultation service at UCSF to answer questions regarding the provision of abortion care.

Data Collection

Data collection took place in three phases: before, during, and after the intervention. Baseline data was gathered using self-administered surveys that were mailed to physicians in the eight intervention and control counties. Baseline data was collected in May of 2004, six weeks before the start of the intervention. Written consent forms were not required by the UCSF IRB, however, a letter describing the purpose of the study and the option not to participate was sent along with the survey and a $5.00 cash incentive. The survey was preceded one week by a letter announcing its' imminent arrival and was followed one week later by a reminder card. A second survey was sent to non-responders two weeks later.

During the intervention phase (June 2004-December 2004), the clinician educators collected relevant data about the practices and their interactions with staff and/or the target physicians at each visit using an electronic database designed for this purpose. They documented quantitative aspects of their experiences (e.g., number of messages imparted, time spent discussing methods) as well as their qualitative

observations (e.g., characteristics of the clinical practice, receptivity of the physician). At several points throughout the study qualitative interviews were conducted with the clinician educators to capture experiences and assessments of their successes and challenges.

After the intervention, in January 2005, follow up surveys were mailed to the control and intervention physicians. Follow-up surveys were administered using the same survey protocol as the baseline survey, and included several identical questions about knowledge, attitudes, and practices related to the detailed products as well as barriers to and facilitators of provision of the detailed products. Finally, the physicians were asked whether they remembered being visited by a clinician educator (pictures were provided to prompt memory) and whether the information provided was useful and helpful.

Statistical Procedures

All data were analyzed using STATA version 8.2 (Stata Corporation, College Station Texas). We used bivariate and multivariate analysis to examine abortion knowledge, opinions, and provision. In the bivariate analysis, we used Chi-square statistics to measure differences in abortion attitudes by physician specialty (internal medicine, family and general medicine, and obstetrics and gynecology) and referral practices. Multivariate analysis used three demographic factors--age, race/ethnicity, sex--and five practice variables--physician specialty, practice type, association with an HMO, Medi-Cal participation, and percentage of reproductive age women served.

To study physician's opinion about the need for abortion services to be made more available to women, we modeled using a multivariate logistic regression. Physician

agreement with the statement "Women in the community where I practice would benefit if abortion services were more widely available" was coded dichotomously with predictor variables including; whether the physician is located in a treatment or control county; and abortion attitudes. We employ three models: the first uses just descriptive variables, the second includes descriptive variables plus whether the provider is located in a treatment county and the third includes the variables in the second model plus three two questions about abortion attitudes.

The overall effect of detailing was assessed by comparing key baseline knowledge, attitudes and practice questions with those reported at follow-up. Changes in physicians' knowledge and attitudes about mifepristone were analyzed using paired t-tests for changes in means for physicians in the control and the intervention counties. Mean scores were calculated by assigning a numerical value to each level of familiarity (1=very familiar, 2=somewhat familiar, 3=not too familiar, 4=not familiar at all familiar, 5=don't know). Physicians' willingness to provide mifepristone was also calculated using paired t-tests. Values were assigned for each level of likelihood of providing in the next year (1=very likely, 2=somewhat likely, 3=not too likely, 4=not likely at all, 5=don't know).

Study Results

This section presents the results of the baseline and follow-up surveys as well as the effects of the detailing intervention with regard to medication abortion. General opinions about abortion and the need for abortion care are provided, as well as specific opinions about mifepristone. Information about current practices and future intentions

regarding abortion provision is revealed. Finally data is presented on the process and outcomes of the academic detailing intervention.

Overall Study Population

Table 1 presents the demographic profile for the overall study population with respect to three variables: medical specialty, age, and years since graduation. Obstetrician-gynecologists (ob/gyn) comprised only 15% of the overall study sample, while family and general physicians (FM/GM) comprised over half (51%), and internal medicine physicians (IM) the remaining 34%. Approximately one third of the study population was less than 45 years of age, while another third was between 46-55 and the remaining third over age 55. The physicians were established providers with only a fifth of the population in practice less than 10 years.

[Table 1 about here]

Survey Sample

The baseline and follow-up surveys collected more detailed demographics and, as such, these data are only available for the subset of physicians that returned either of those questionnaires ("survey sample"). See Table 1 for complete data. A total of 754 physicians returned the baseline survey (53%) and 581 physicians returned the follow-up survey (41%). Of the physicians surveyed, 451 returned both the baseline and the follow-up survey (32%). There were no statistically significant differences between the survey sample and the overall study population for the three variables for which we have data on both: medical specialty, age, and years since graduation.

Overall, the survey sample was predominantly male (73.4% at baseline and 75.5% at follow-up), white (57.0% and 56.4% respectively), not associated with a health

maintenance organization (HMO) (80.1% and 84.6%), and in either group (33.1% and 34.1%) or solo (28.4% and 30.4%) private practice. Almost two-thirds of the sample accepted Medi-Cal, the California state Medicaid program, but less than one-quarter indicated that they were registered providers with the state family planning program, Family PACT. Almost three-quarters of the physicians reported that women of reproductive age made up less than half of their patient population. Only a limited number of physicians (6.5% at baseline and 9.1% at follow-up) indicated that women of reproductive age made up the majority (between 75%-100%) of their practice. No statistically significant differences were found between those physicians that returned the baseline and the follow-up surveys, except for race/ethnicity. Asian physicians comprised more of the population that completed the follow-up surveys than in the baseline survey (25.1% at baseline and 30.3% at follow-up).

Baseline Survey Results

Opinions About Abortion

At baseline, physicians were asked whether they thought abortion should be: "Legal under any circumstances," "Legal only under certain circumstances," "Illegal in all circumstances" or "No opinion." Overall, physicians expressed widespread support for legal abortion (see Table 2). Eighty-six percent of physicians opined that abortion should be legal in any or some circumstances; only 7.9% stated that abortion should be illegal in all circumstances. The remaining 6.5% had no opinion. Significant differences in abortion opinions were identified across provider types. Among those with an opinion, family/general medicine physicians were more likely to believe that abortion should be illegal than were either internists or ob/gyns (9.9% vs. 5.5% vs. 6.8%). Internal medicine

physicians were more likely to have no opinion than either ob/gyns or family/general medicine physicians (11.0% vs. 1.0% vs. 4.8%).

[Table 2 about here]

Logistic regression was performed to test for the effect of demographic and practice level variables (see "Statistical Procedures" section earlier for a listing of these variables) on opposition and support for legal abortion. None of the variables included were significant predictors of support for or opposition to abortion.

Physicians were also asked whether personal opposition to abortion was the reason they did not perform abortions (see table 2). Overall, only 38.3% of the respondents answered that they agreed with the statement "I do not perform abortions because I personally oppose this practice."[6] Correspondingly, half of the physicians who did not perform abortions expressed no personal opposition to abortion. An additional 9% reported that they did not know whether moral opposition to abortion was their reason for not performing abortions. No statistically significant differences were found across provider types.

Knowledge, Attitudes and Beliefs about Mifepristone in Primary Care

At baseline, almost three-quarters of the study sample physicians were either "very familiar" or "somewhat familiar" with medication abortion. See Table 3. Most physicians believed that mifepristone was either "very effective" or "somewhat effective" (65.2%) and either "very safe" or "somewhat safe" (60.6%). An additional 35% did not know whether it was effective or safe. Logistic regression was performed to assess the

[6] This question was taken from surveys conducted by the KFF regarding abortion provision. Although a double negative and thus somewhat awkward to report on, the question's repeated use in national representative surveys allowed for comparison with the findings of this study.

effect of demographic variables and practice level variables on familiarity with mifepristone. Not unexpectedly, those providers for whom serving women of reproductive age was less than 25% of their practice were half as likely as those serving more women of reproductive age to be familiar with mifepristone for medication abortion (OR 0.46, $p<.05$). No other statistically significant differences were found.

[Table 3 about here]

Since the goal of the intervention was to promote the uptake of mifepristone within the clinical setting of the physician, the survey asked whether the physician believed that mifepristone could be safely provided in primary care settings (see Table 3). Over half of physicians responded that they believed it could be used safely; an additional 28.7% responded that they did not know. No significant differences were found comparing the responses of ob/gyn specialists with the more traditional primary care providers (family, general and internal medicine physicians).

Finally, physicians were asked at baseline and prior to the intervention how likely they were to provide medication abortion in the next year. Only 11.8% reported being either "very likely" or "somewhat likely" to provide the method, while over 75% of the respondents stated that they were "not too likely" or "not at all likely" to provide medication abortion in the next year. An additional 9.4% reported that they did not know whether they were likely to provide medication abortion in the next year.

Performance of Relevant Clinical Services

Physicians were asked at baseline about a range of pregnancy-related services. The physicians were asked to indicate whether they provided the service, made referrals for the service, or did not provide nor refer for the listed service. Those services related to the provision of abortions are in Table 4.

[Table 4 about here]

The large majority (80.6%) of physicians reported offering contraceptive counseling. Despite almost 90% of physicians offering pregnancy testing, only 61.4% indicated that they provided pregnancy options counseling. Only 28.9% of physicians performed ultrasound in their clinical practice. No differences were found across provider type for any of these clinical services.

Few physicians (3.5%) stated that they performed abortions. Nearly half of the respondents neither performed abortion nor referred patients for abortion. Further analysis revealed additional insight into the lack of abortion referral. Among those that did not do abortions nor refer patients for abortion, only one-third believed that abortion should be illegal in all circumstances. Interestingly, among those that do not believe abortion should be illegal, over 40% neither did abortions nor referred for abortions. Significant differences were found between those who do and do not refer with regard to the role of moral opposition to abortion as their reason for not performing abortions ($p<.05$) with those physicians that morally opposed doing abortions less likely to refer for abortions (see table 4). However, 40.4% of the physicians who do not provide abortion referrals were not morally opposed to abortion.

Logistic regression was performed to test the effect of demographic and practice level variables on referral for abortion among those physicians that do not do abortions themselves. Male physicians were found to be half as likely as their female colleagues to refer for abortion (OR 0.56, $p<.05$). Physicians in community or family planning clinics were found to be as twice as likely to refer for abortion as those in group private practice (OR 2.00, $p<.05$). Surprisingly, family/general medicine and internal medicine physicians were twice as likely as ob/gyns to refer for abortion (OR 2.07, $p<.05$ and OR 1.90, $p<.05$ respectively).

Opinions About the Need for Increased Access to Abortion Care

The baseline survey sought to assess whether physicians thought there was a need for expanded abortion care in their communities. Physicians were asked to indicate how strongly they agreed or disagreed (i.e., "strongly agree," "agree," "disagree," "strongly disagree," or "don't know") with the following statement: "Women in the community where I practice would benefit if abortion services were more widely available." Opinions about the need for additional abortion services did not vary across provider type. Overall 44.5% of physicians either "strongly agreed" or "agreed" with the statement that women would benefit; 36.8% either "disagreed" or "strongly disagreed" with the statement, and a remaining 18.7% did not know.

Logistic regression models were developed to understand predictors for opinions about the need for increased access to abortion. The results are in Table 5. When demographic and practice level variables were included in the analysis (Model 1), males were half as likely to agree that women would benefit, while Medi-Cal providers were 1.5 times as likely to believe that women would benefit from more abortion services.

Unfortunately this model explained less than 5% of the difference. For Model 2, whether the physician was in a treatment or control county was included to test for the effect of geographic differences. Little change was seen.

[Table 5 about here]

For Model 3, we included two opinion questions asking: whether the reason that the physicians did not do abortions was because of moral opposition to abortion, and whether the physicians believed providing medication abortion was safe in a primary care setting. When these two variables were included, the effect of being male disappeared although the effect of being a Medi-Cal provider remained (OR 1.74, $p<.05$). Being in a solo private practice setting became significant in this model with an OR of 2.15. Most interesting in this model was that disagreeing with the statement that the decision to provide abortions was the result of moral opposition to abortion resulted in 94% less likelihood of believing there was a the need for more abortion care ($p<.01$). Put more plainly, those that did not do abortions but were not morally opposed to doing abortions did not believe there was a need for greater access to abortion care for the women in their community. Those who answered "do not know" were also significantly ($p<.01$) less likely to see a need for more abortion care (OR 0.21). By comparison, agreeing with the statement that medication abortion is safe in a primary care setting resulted in an almost six-fold increase in recognition of the need for expanded abortion care. This third model explained 31.6% of the differences found in opinions about the need for expanded abortion care

Physicians who "strongly agreed" or "agreed" that women would benefit from more abortion care were also significantly more likely to be "very likely" or "somewhat likely" to provide mifepristone in the next year ($p<.01$).

Detailing Results

The Process of Detailing

The total number of visits made to the intervention physicians' offices and the number of visits that involved at least one intervention message was analyzed. Although the two clinician educators were able to make 434 visits to the intervention physicians, only 140 of those visits involved discussing one or more of the tiered intervention messages (32.2%). Success varied substantially across counties [range 18.6%-55.2%].

The number of visits per physicians was also analyzed. Of the 193 physicians randomized to receive the intervention, only 92 (47.7%) actually received an intervention visit that involved at least one of the study's tiered messages. These rates also varied by county [range 33%-57%]. Despite the study's intention to visit every intervention physician several times over the course of the intervention, 61% of the physicians reached received only one visit and an additional 28.3% received two visits. Only two physicians received more than three visits where a tiered message was given.

Time spent disseminating the tiered messages was also tracked. Overall, 232 tiered messages were given with an average time of six minutes spend on the actual visit that involved a tiered message. Seventy-seven percent of visits where a messages was lasted between one and five minutes, 16.4% took between 6 and 10 minutes, 4.7% between 11 and 20 minutes, 2.1% between 21 and 60 minutes, and only one visit took over an hour to provide.

During the course of the intervention, no physicians took advantage of the opportunity to be reimbursed for mifepristone. Similarly, no physicians utilized the referral phone service.

The Effect of Detailing: Knowledge About and Willingness to Provide Mifepristone

We evaluated the overall effect of detailing by comparing key baseline knowledge, attitudes and practice findings with those reported at follow-up. Changes in physicians' knowledge and attitudes about mifepristone were analyzed using paired t-tests for changes in means for physicians in the control and the intervention counties. Lower mean scores reflect greater familiarity with mifepristone. Significant differences were found between the mean scores of those physicians who received the intervention and those who did not. At follow-up, the difference in mean scores for familiarity with medication abortion was 2.31 for those that were detailed and 2.71 for those that were not ($p<.05$). Results are presented in Table 7.

Again, using paired t-tests for change in means, we examined physicians' willingness to provide mifepristone among those who received detailing and those who did not (see Table 7). Lower mean scores reflect greater willingness to provide medication abortion. Significant differences ($p<.01$) were found in the physicians' likelihood of providing mifepristone between those that were detailed (3.03) and those that were not (3.53).

[Table 7 about here]

One concern about pre- and post-test methodology for assessing knowledge, attitudes and beliefs is that the survey itself serves as a form of education. We tested for the effect of the baseline survey among those physicians who were not detailed and who

returned both the baseline and the follow-up survey (N=360). We found no significant differences between the two groups.

As a result of this study, ten physicians requested additional training and information about medication abortion directly from UCSF. After the follow-up data was collected, study staff conducted an all-day training on abortion care for those physicians who were interested. We do not know, however, whether these providers have initiated new abortion services.

Acceptability of Academic Detailing

Of the 91 physicians who received a detailing visit, 35 returned the follow-up survey. These surveys were examined to assess acceptability of the intervention. Eighty percent of those who received detailing and completed the follow-up survey reported that they found the information to be "somewhat useful" or "very useful" and that the experience was either "helpful" or "somewhat helpful" (see Table 8.). In addition, 36.4% reported that they believed that the academic detailing experience had improved their understanding of mifepristone.

[Table 8 about here]

A small number (n=28) of the physicians who were detailed returned both the baseline and the follow-up survey. The experiences of these physicians are of special interest. Of those for whom both baseline and follow-up data exists, there was positive movement in familiarity with abortion for 11 physicians. Three physicians experienced a negative direction change and 13 physicians remained unchanged, with one failing to answer the question. Regarding willingness to provide mifepristone in the next year, nine physicians (32.1%) noted an increased willingness to provide mifepristone. Eleven did

not change in their willingness to provide (including the 3 that were already very likely to provide mifepristone in the next year), three experienced a negative directional change, and five failed to answer either the baseline or the follow-up question.

Experience of the Detailers

Qualitative data was collected from the clinician educators throughout the course of the study to track progress and document the experience of conducting academic detailing. This information was analyzed to identify key features of the detailing experience.

Data indicates that gaining access to the physician was one of the most challenging aspects of the project. In an interview conducted after the initiation of the study, one clinician educator summed up her experience: "Probably the greatest challenge is just finding creative ways around the gatekeepers." These "gatekeepers," as they were called by pharmaceutical detailers the clinician educators encountered while waiting in physicians' offices, are the people (often the front office staff) that determine whether or not someone is allowed to see the physicians. When supportive, these gatekeepers can enhance the detailing experience. Conversely, when they are not supportive, they can thwart it. Diaries revealed that problems with gatekeepers varied by county with practices in more urban cities having more resistant gatekeepers, perhaps as a result of the large number of pharmaceutical detailers also visiting these practices.

Diary entries made by the clinician educators told of encounters with gatekeepers. Sometimes the experience was a positive one: "Before I spoke with each [doctor], the gatekeeper had a little private talk with them to prepare them for me. After talking to the fourth doc, I thanked the gatekeeper for being so sweet in making the docs available to

me, and she said that she thinks this work is really important and she wants her docs to have this information." By comparison, another clinician educator wrote in her diary about her experience with a obstructionist gatekeeper. Upon returning to a practice on a date when a very hostile gatekeeper was gone, she wrote: "I finally got in to see the last [city name] doc (the dragon lady was out) and he was charming...Both [he and the nurse practitioner] were very into the messages...What a surprise. I had been ready to write them off."

Consistent with the findings of other academic detailing studies, focusing on the academic, unbiased backing of the project was one successful strategy in overcoming gatekeeper resistance. As one clinician educator explained: "But even [the doctors' offices] that are hesitant seemed to be impressed by UC San Francisco and this as a project that the University is working on. When I started [sic] saying that, it seemed like the doors opened much more quickly." Another successful strategy was to provide general women's health information to the staff, usually female, who work in the physicians' practices. These materials were not meant to be passed on to the target physician; rather there were selected to meet the age range and interest of the staff. This strategy was particularly important in large clinical settings where there were many more "gatekeepers."

Overall, most physicians were open to receiving the academic detailing visits. As one academic detailer explained: "I was surprised at [sic] the number of people who were interested in broaching the [abortion] topic and having a discussion about it." Few physicians demonstrated overt hostility toward the disseminated messages. When encountered, this opposition was usually to the full range of pregnancy prevention

technologies not just to elective abortion. One detailer explained such an experience, "[a doctor] gave me a speech about how he cares for the whole woman and so he doesn't prescribe birth control to anyone except married women in a mutually monogamous relationship."

Physicians' concern about community reaction to abortion provision was expressed in some conversations with the clinician educators, as one explained: "Probably the majority [of physicians] that I visited were at least interested [but] in that extremely conservative area, over and over and over again what I heard from the docs is the religious right is extremely well organized here. [The physicians believed that] if any word got out there would be people picketing out in front." Another story by a clinician educator described how this risk had played out for one of the physicians she visited: "[One physician] had actually used [office abortion] procedures in the past to manage incomplete abortion [aka miscarriage] but had to stop because word got around the community that he was doing abortions in the office. He got a delegation of angry women confronting him in his waiting room in front of patients and actually lost patients because of it."

Diaries from the clinician educators reveal that the randomization of physicians within the intervention county led to problems with missing potential new providers of mifepristone. On several occasions, the target physician wanted to refer the academic detailer to a colleague who "would be really interested in the information" but that referred physician was part of the control study sample. Ability to make change was affected when the head medical person in a practice was not an intervention physician.

Discussion

This study reached a population of physicians not currently providing medication abortion. Prior to the intervention, physicians in our study demonstrated relatively low knowledge of the efficacy and safety of mifepristone and few physicians intended to offer the service within the next year. There was, however, widespread support for legal abortion. Moral opposition to abortion was not the stated reason many physicians did not provide abortion care. Interestingly, many of the physicians who did not do abortions but who did not believe abortion should be illegal, did not refer for abortions. There was substantial recognition among physicians that women in their communities would benefit if abortion services were more widely available and recognition of need was significantly associated with a willingness to provide medication abortion. Physicians' willingness to provide medication abortion was also significantly associated with receiving academic detailing, which physicians found both useful and helpful. However the process of detailing was labor intensive with limited access to and time with the intervention physicians.

The results of this study suggest that academic detailing may be one way to increase awareness of and potential use of mifepristone for medication abortion. Future academic detailing efforts to promote medication abortion should be informed by both the successes and limitations of this project. Future replication efforts should: use better methods to identify target physicians, target the whole practice, limit the number of messages given, and rethink the "product" being detailed.

Reaching the Right Population

This study was successful in reaching the desired target audience of primary care providers in private practice settings located outside metropolitan areas. Eighty-five percent of the study physicians were non-ob/gyn providers and, for almost 75% of the physicians who responded to the survey, care for women of reproductive age comprised less than half of their clinical practice. Over 96% of the physicians did not currently provide abortion care. These providers did, however, routinely offer other services relevant to the performance of abortion, including contraceptive counseling, pregnancy testing, and pregnancy options counseling. There were no significant differences between ob/gyn, family/general medicine, and internal medicine with regard to the abortion-related services offered, including ultrasound, which is often used in the provision of medication abortion.

The low levels of knowledge about the safety and efficacy of mifepristone at baseline suggest that the study successfully reached a pool of physicians without prior information about medication abortion. In order to confirm this conclusion we compared the baseline knowledge of the physicians in our study with a large nationwide study performed by the KFF (2001b). Although questioned three years earlier, the physicians in the KFF study demonstrated significantly greater knowledge of mifepristone than the physicians in our study. Eighty-two percent of the ob/gyns in the KFF study reported being either "very familiar" or "somewhat familiar" with mifepristone, while only 41% of the ob/gyns in our study had similar levels. Likewise, 61% of the general practice physicians (family medicine, general medicine and internists) in the KFF survey were "very familiar" or "somewhat familiar" with mifepristone while only 43% of the general

practice physicians in our sample were "very familiar" or "somewhat familiar" with mifepristone at baseline. One reason for these differences may be the rural focus of our study.

Finally, this study was also successful in reaching physicians not currently contemplating offering medication abortion. At baseline, only 11% of the physicians indicated that they were "very likely" or "somewhat likely" to provide medication abortion in the next year. These results contrast with other surveys that found higher interest in offering medication abortion when sampled physicians were asked the same hypothetical question regarding use (Heilig, 1992; Miller, Miller, & Pinkston Koenigs, 1998; Rosenblatt, Mattis, & Hart, 1995; The Henry J. Kaiser Family Foundation, 2000).

Physician Support for Legal Abortion and Access to Abortion

This study suggests that primary care physicians in rural California continue to support legal abortion. Although differences across physician specialty were present at baseline, they did not reappear at follow-up, where more physicians stated that they had no opinion about the legal status of abortion. Unlike prior studies (American College of Obstetricians and Gynecologists, 1985; Weisman, Nathanson, Teitelbaum, Chase, & King, 1986; Westfall, Kallail, & Walling, 1991), this study did not find significant gender differences in support for or opposition to legal abortion.

While many physicians in our survey indicated that they do not offer abortions, we identified that moral objection to abortion was not the reason the surveyed physicians do not perform abortions. These results contrast with the results of a study in rural Idaho (Rosenblatt, Mattis, & Hart, 1995), where the most important reason family physicians gave for not performing abortion was their personal moral or religious objection (82%).

Both the overall level of support for legal abortion and the lack of moral opposition to abortions may indicate that performance of abortion is not inconsistent with the value systems of the physicians being detailed, thus meeting the compatibility standards set out by Rogers (2003). Rather, other barriers to provision may be important to understanding the diffusion of this abortion modality.

The lack of referral for abortion was substantially higher than expected. In the Rosenblatt study, 65% of those morally opposed to abortion were willing to refer patients requesting abortions to another provider. In a 1985 ACOG poll, 83% of physicians who supported abortion referred for care while only 55% of those that opposed abortion referred for such care. In a Westfall study of Kansas general physicians, only 23% of physicians did not refer women for abortion. Our study, however, found that almost half of the surveyed physicians did not do abortions nor refer their patients to abortion providers. Lack of referral was also very high even among physicians that did not believe abortion should be illegal or who were not morally opposed to performing abortions. The reasons for this lack of referral cannot be answered by this study. Avenues for future research include exploration of whether physicians lack the information about where to refer patients, they are concerned that the community will find out they referred a patient for an abortion, or their patients do not request such referrals from them.

Another notable result of this study was the extent to which physicians believed that women in their communities would benefit from expanded abortion services. Hassiner (1959) argues that individuals must first feel a need for the innovation before they expose themselves to innovation messages. The results of this study support this

conclusion. Physicians who recognized a need for additional abortion services in their communities were more likely to consider offering mifepristone in their practice. Future work should investigate whether increasing physician's awareness of the need for abortion by the women in their community can make otherwise unwilling physicians more likely to provide medication abortion. Physicians who believed mifepristone was safe in a primary care setting were also six times as likely as those that did not to recognize the need for expanded abortion access for women in their communities. Either question may be a good screening question for future more targeted efforts to persuade physicians to being offering medication abortion.

Increasing Abortion Provision

The results of this study demonstrate that prior to the intervention many of California's rural physicians lacked adequate knowledge of mifepristone and had not considered offering medication abortion. Because significant differences in knowledge and attitudes about mifepristone were found between the detailed population and the physicians who were not detailed, it is possible that the academic detailing carried out in this study may have moved some physicians through the first two stages of Rogers model for diffusion: knowledge and persuasion.

The challenge for those who seek to expand access to abortion care is to move physicians considering offering abortion to the implementation stage and to continue to sustain them as abortion providers. Additional training, as provided to some physicians in this study, may be sufficient while other physicians may need future follow up. Still other physicians may prefer to implement medication abortion services without anyone, including the clinician educators, knowing about it. The challenge for those that study

the diffusion of medication abortion is that the very characteristic that makes medication abortion attractive, namely that it can be done privately in a physician's office without the community learning about it, is the very feature that makes assessing the success of an academic detailing project almost impossible. However, since the counties selected for the intervention had one or fewer publicly-advertised abortion providers at the time of the intervention, the increase in abortion provision by even a few physicians may represent a meaningful change for women.

Strategies for Replication

In general, this study supports the conclusion of prior studies that academic detailing is an effective method for bringing information directly to physicians and in contributing to significant changes in knowledge, attitudes or practices. This project represented a bold initiative to expand access to medication abortion by using academic detailing to reach physicians in practice in rural California. It was perhaps naive to assume that a six-month intervention would result in substantial physician behavior change surrounding such a highly politicized issue. The positive results of this study, however, support future replication of this effort with several modifications to the intervention design. Specifically, future studies should use better methods to identify potential providers to receive the intervention; the intervention should be targeted at the practice as a whole; the content of the intervention should include fewer more targeted messages; and the "product" being detailed should address the provision of abortion, referral for abortion, as well as the need for abortion services.

Better Methods of Identification of Targeted Providers

One unexpected complication of this study was the large number of physicians that we were unable to contact. A high percentage of the information on the AMA masterfile was incorrect and no resource was available to obtain more current information. Use of local phone books was labor intensive and surprisingly limited in usefulness. This inability to contact physicians by phone to screen them for study inclusion, combined with the randomization of physicians within the intervention counties to the detailing intervention, severely limited the number of physicians targeted for the intervention. Given that the detailer is required to travel long distances between communities, it may be more resource efficient to target all physicians in a given geographic area, regardless of prior identification for inclusion in the study. In addition, several opportunities to "pick the low lying fruit" were missed. Snowball sampling might be more fruitful and less resource intensive. The original interest in studying diffusion within intervention counties between control and intervention subjects could not be met as the sample size was too small. As such, the randomization did not add to the study evaluation but rather created an unnecessary barrier to information diffusion.

This study used a general question regarding serving women of reproductive age as a means for inclusion as a target physician. While this inclusive approach allowed for the reaching of many physicians that had not previously known about or considered offering medication abortion, it was resource intensive. The results of this study suggest the value of using two screening questions to identify those providers that are more likely to consider offering medication abortion. The first solicits the provider's recognition of the need for abortion services for the women in the community where s/he practices. The

second question asks whether the physician believes that mifepristone can be safely provided in a primary care setting. Both of these questions were significantly associated with willingness to provide medication abortion.

Targeting the Practice as a Whole

Access to the physician was often a challenge for the clinician educators who encountered resistant staff personnel, called "gatekeepers." The design of this study was geared to intervene directly with the individual physician. A more fruitful strategy might be to target the entire practice and to specifically focus on the educational needs of the gatekeepers. Several strategies were used as part of this project to try to overcome barriers with gatekeepers including stressing the academic nature of the project, providing general women's health information, and offering small tokens of food, but this study did not systematically study these techniques and, as such, can not provide evidence as to which strategies are most likely to work. Future academic detailing study should include research questions specifically related to the needs of these staff members.

Limit the Number of Messages

A major flaw of this study design was the inclusion of too many messages. As discussed earlier, the detailers attempted to share three tiered messages for four products: emergency contraception, medication abortion, manual vacuum/uterine aspiration, and the state Family PACT Program. In this study, the large number of messages to be presented to the physician meant that multiple visits rarely served to reinforce prior information but, rather, to impart new information about several technologies. Few physicians received more than two visits and, thus, not all of the tiered messages for medication abortion were imparted. Both as a result of strict gatekeepers and limited

physician availability, the clinician educators were unable to cover all aspects of the products being detailed. Thus, individual messages were diluted and there was inadequate time to discus the more controversial issues such as abortion technologies, which may require more discussion to overcome barriers to provision. Future efforts to use academic detailing to disseminate information should limit the number of messages and select a single product to promote.

Detailing Referral and Need for Abortion Services

The low rates of referrals for abortion that we observed in this study among physicians who are not morally opposed to abortion or who do not believe abortion should be illegal provide direction for further investigation. Future efforts to promote provision of abortion may wish to include information on how and where to refer patients in need of abortion as a component of the outreach. As male physicians were half as likely to refer as their female colleagues, special attention should be paid to the gender aspects of this issue. Women's access to abortion care may be facilitated, not only by increasing the number of physicians who provide abortions, but also by increasing the number of physicians who refer for abortions.

This study also found that recognition of need for abortion among women in their communities was significantly associated with a physician's willingness to provide medication abortion. Future work should explore the extent to which persuasion around the need for abortion access is important to moving physicians to begin offering medication abortion.

Conclusion

The number of abortion providers continues to decline in the United States and access to abortion is particularly limited for low-income women, women of color, and geographically-isolated women, including in California. One potential solution to redress this decline is the diffusion of mifepristone for medication abortion use by physicians outside the traditional abortion clinic setting. This paper presents and discusses the results of a study that used "academic detailing" to reach primary care physicians in practice in rural California. Academic detailing is an evidence-based means of changing physician behavior. Using face-to-face outreach visits, clinician educators visited a random sample of physicians in four intervention counties in California in their practice settings. They disseminated standardized tiered messages regarding advances in reproductive health along with standardized materials and resources. After a six-month intervention, significant differences in familiarity with and willingness to provide medication abortion were found between those physicians who received detailing and those who did not. However, the study can not determine whether the physicians' provision of medication abortion changed as a result of the intervention. Further, the process of detailing was labor intensive with many visits not including the dissemination of a tiered message, and those that did include a message were very short in duration.

The results of this study suggest that academic detailing may be one means by to reach physicians without prior knowledge of or interest in providing medication abortion. The almost universal support for legal abortion, and the low levels of moral opposition to abortion provision suggest that values barriers are not the major obstacle to overcome. Additional encouragement for abortion diffusion is found in opinions of physicians that

women in their communities would benefit if abortion services were more widely available and the belief that mifepristone can be offered safely in a primary care setting. Questions about these attitudes may serve as appropriate screening tools for future identification of physicians with a greater likelihood of adopting medication abortion.

Several lessons from this project have implications for other academic detailing efforts generally and in regards to medication abortion specifically. Better identification of targeted health care providers should be complemented with interventions at the practice rather than the individual level. In addition, attention to the specific needs of the so-called "gatekeepers" is important to the success of any academic detailing undertaking. While the number of products being detailed should be limited, the content of what is being detailed should be more comprehensive than simple introduction of the technology. In the case of medication abortion, the information detailed should address how to make abortion referrals, the need for expanded access to abortion, as well as how to incorporate abortion services into clinical practice.

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Figure 1: Overall Study Design and Participation

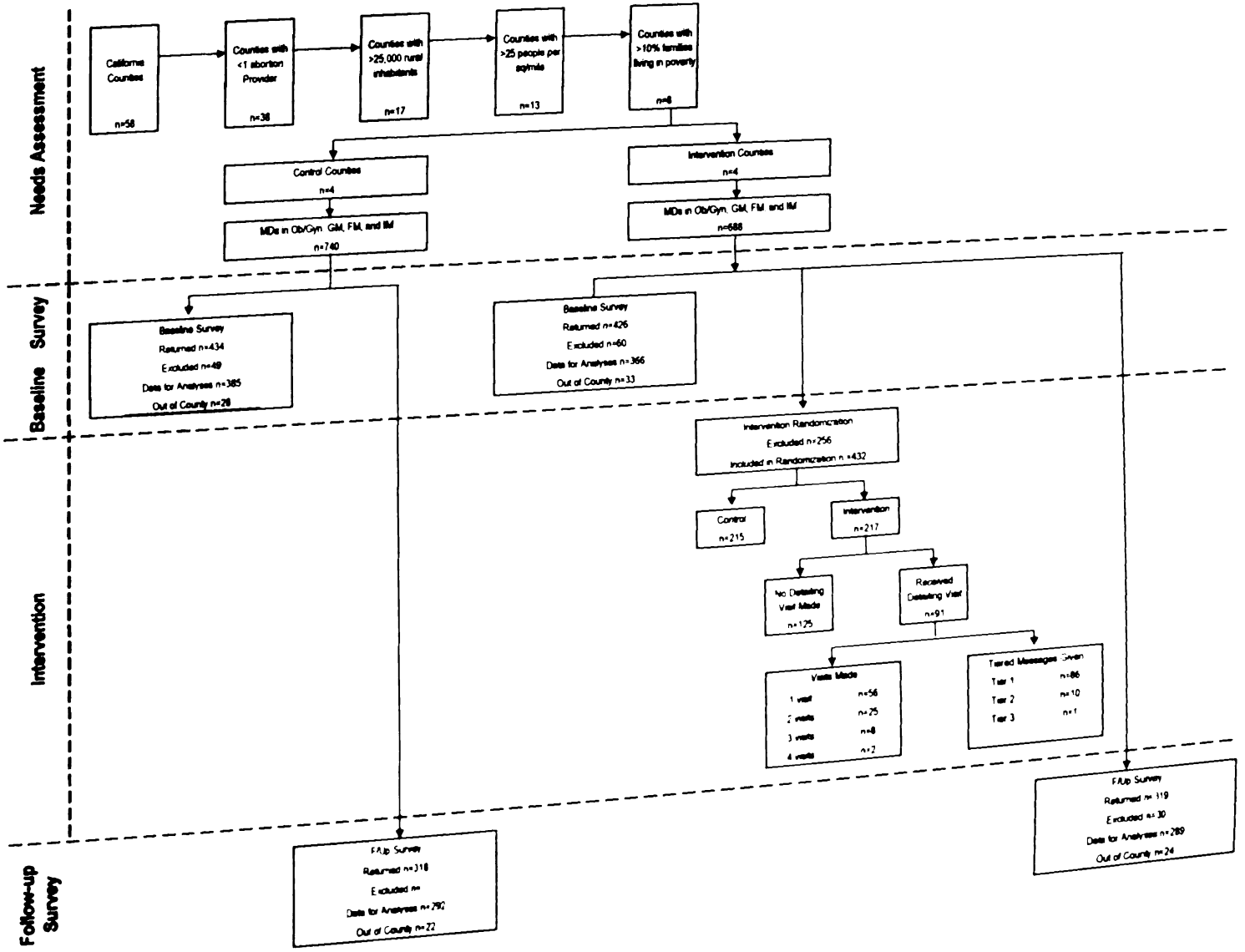

Table 1: Demographics of Overall Study and Survey Populations

	Study Population	Survey Population	
		Baseline	Follow-Up
Total	n=1428	n=754	n=581
	%	%	%
Specialty			
Family and General	51.1%	49.2%	50.3%
Internal Med	33.8%	35.8%	36.0%
Ob Gyn & Gyn	15.1%	15.0%	13.8%
Age			
<35	9.9%	12.5%	9.8%
36-45	25.7%	26.9%	27.0%
46-55	31.8%	30.1%	32.4%
56-65	20.6%	20.0%	19.1%
>65	12.0%	10.5%	11.7%
Years Since Grad			
<10	20.9%	17.8%	18.2%
11-20	28.6%	28.6%	30.3%
21-30	26.9%	26.7%	26.2%
31-40	14.4%	17.1%	15.5%
>40	9.2%	9.8%	9.8%
Sex			
Male	--	73.4%	75.5%
Female	--	26.6%	24.5%
Race/Ethnicity*			
White	--	57.0%	56.4%
Black	--	3.2%	3.1%
Hispanic	--	11.6%	9.7%
Asian	--	25.1%	30.3%
Other	--	3.2%	0.5%
Associated with HMO			
Yes	--	18.0%	14.2%
No	--	80.1%	84.6%
Don't Know	--	1.9%	1.2%
Practice Type			
Group private practice	--	33.1%	34.1%
Solo private practice	--	28.4%	30.4%
Community health /FP	--	17.1%	15.7%
Hospital based	--	8.3%	6.2%
Other	--	13.2%	13.5%
Medi-Cal Provider			
Yes	--	67.5%	63.7%
No	--	31.9%	34.9%
Don't Know	--	0.7%	1.4%
FamilyPACT Provider			
Yes	--	24.1%	21.2%
No	--	57.2%	62.3%
Don't Know	--	18.8%	16.5%
% of Practice that is Women Aged 15-44			
0%	--	3.5%	6.4%
1-25%	--	36.4%	39.9%
26-50%	--	33.4%	26.9%
51-75%	--	20.2%	17.7%
76-100%	--	6.5%	9.1%

*$p<0.05$

Table 2: Opinions about Abortion at Baseline

	FM/GM	IM	ObGyn	Total
"I think abortion should be..."*				
Legal under any circumstances	42.0%	40.2%	36.9%	40.6%
Legal only under certain circumstances	43.4%	43.3%	55.3%	45.1%
Illegal in all circumstances	9.9%	5.5%	6.8%	7.9%
No opinion	4.8%	11.0%	1.0%	6.5%
Total	100%	100%	100%	100%
	n=355	n=254	n=103	n=712
"I do not perform abortions because I personally oppose this practice."				
Agree	39.1%	36.5%	40.2%	38.3%
Disagree	51.5%	52.2%	51.1%	51.7%
Don't know	9.4%	11.3%	8.7%	10.0%
Total	100.0%	100.0%	100.0%	100.0%
	n=330	n=230	n=92	n=652

*$p<.05$

Table 3: Opinions and Knoweldge of Mifepristone at Baseline

Survey Question	%
How familiar are you with mifepristine for medication abortion?	
Very familiar	37.6%
Somewhat familiar	37.6%
Not too familiar	14.9%
Not familiar at all	7.5%
Don't Know	2.4%
Total	100.0%
	n=716
How effective is medication abortion with mifepristone?	
Very effective	40.2%
Somewhat effective	25.0%
Not too effective	0.4%
Not at all effective	0.1%
Don't know	34.2%
Total	100.0%
	n=691
How safe is mifepristone when used under medical supervision?	
Very safe	30.3%
Somewhat safe	30.3%
Not too safe	3.6%
Not safe at all	0.9%
Don't Know	34.9%
Total	100.0%
	n=687
Medication abortion (using mifepristone) can be safely provided in primary care settings	
Stongly Agree	11.8%
Agree	38.8%
Disagree	13.1%
Strongly Disagree	7.5%
Don't Know.	28.7%
Total	100.0%
	n=703
How likely are you to provide MAB in the next year, in this or any practice?	
Very likely	3.0%
Somewhat likely	8.8%
Not too likely	22.2%
Not at all likely	56.6%
Don't Know	9.4%
Total	100.0%
	n=668

Table 4: Provision of relevant clinical services within the physician's practice at baseline

Clinical Service	Yes	Make Referral	Do not do Nor Refer
Contraceptive Counseling	80.6%	9.9%	9.5%
Pregnancy Testing	89.3%	3.5%	7.2%
Pregnancy Options Counseling	61.4%	21.0%	17.6%
Prenatal Care	36.5%	34.9%	28.6%
Ultrasound	28.9%	39.9%	31.1%
Elective Abortion	3.5%	48.0%	48.5%

Moral Opposition to Doing Abortion* *"I do not perform abortions because I personally oppose this practice."*	Do Refer for Abortions	Do not Refer for Abortions
Agree	48.9%	26.7%
Disagree	40.4%	63.8%
Don't know	10.7%	9.5%
Total	100.0%	100.0%

$p<.05$

Table 5: Predictors of Agreement that Women in Their Commuities would Benefit from Greater Access to Abortion Care

	Model 1 OR	Model 2 OR	Model 3 OR
Specialty			
Family and General	1.00	1.00	0.78
Internal Med	0.91	0.91	0.63
Ob Gyn & Gyn	--	--	--
Age			
<35	1.30	1.30	1.44
36-45	1.23	1.23	1.76
46-55	--	--	--
56-65	0.81	0.81	0.70
>65	1.56	1.56	1.68
Sex			
Male	**0.58***	**0.58***	0.63
Female	--	--	--
Race/Ethnicity			
White	--	--	--
Asian	1.22	1.22	1.58
Black	1.11	1.11	2.02
Hispanic	1.47	1.48	1.87
Other	3.89	3.87	1.78
Practice Type			
Group private practice	--	--	--
Community health / FP	1.13	1.14	1.44
Hospital based	1.01	1.02	1.68
Other	0.80	0.80	0.64
Solo private practice	1.49	1.49	**2.15***
Associated with HMO			
Yes	0.96	0.96	1.34
No / Don't Know	--	--	--
Medi-Cal Provider			
Yes	**1.70***	**1.70***	**1.74***
No / Don't Know	--	--	--
% of practice women 15-44			
0-25%	1.09	1.09	0.80
26-50%	1.31	1.31	1.14
51-100%	--	--	--
County			
Control		--	--
Treatment		1.02	1.00
Don't Do Abortions Because Personally Opposed			
Disagree			**0.07****
Agree			--
Don't know			**0.21****
Missing			0.69
MAB is safe in primary care			
Agree			**5.70****
Disagree Don't Know			--
N	470	470	466
Pseudo R^2 =	0.0398	0.0398	0.3156

*p<.05
**p<.01

Table 6: Effect of Detailing on Familiarity with Mifepristone and Likehood to Provide

Group	Obs	Average Score
Familiarity with Mifepristone[+*]		
Not detailed	474	2.71
Detailed	39	2.31
combined	513	2.68
diff		0.41
Likelihood to Provide Mifepristone[++**]		
Not detailed	420	3.54
Detailed	31	3.03
combined	451	3.50
diff		0.51

+ 1=very familiar, 2=somewhat familiar, 3=not too familiar, 4=not familiar at all familiar, 5=don't

++ 1=very likely, 2=somewhat likely, 3=not too likely, 4=not likely at all, 5=don't know

*p<.05

**p<.01

Table 7: Opinions about Detailing

Survey Question	%
How useful was the information?	
Very Useful	40.0%
Somewhat useful	40.0%
Not too useful	14.3%
Not at all useful	0.0%
Don't Know	5.7%
Total	100.0%
	n=35
How helpful is academic detailing?	
Very helpful	31.4%
Somewhat helpful	48.6%
somewhat unhelpful	8.6%
Very unhelpful	0.0%
Don't know	11.4%
Total	100.0%
	n=35
Did your understanding improve?	
Yes	36.4%
No	39.4%
Don't know	24.2%
Total	100.0%
	n=33

CHAPTER 15: CONCLUSION AND FUTURE DIRECTION

Abortion, by many accounts, is the most contested social issue of the modern era. This dissertation examines the implications of medication abortion on abortion care provision in the United States. It begins with a proposed theoretical framework which is a modification of the Estes (2001) model for the study of social policy. The concepts of hegemony and social movements are particularly important to the work laid out later in the dissertation. Section II presents a sociopolitical history of abortion. Through this, the idea that abortion was "medicalized before it was moralized" is established. Specifically this dissertation explores the construction of the abortion is problematic hegemony which results from a particularilized meaning of abortion produced through the interaction of cultural systems (including the sex/gender systems, science, and religion), post-industrial capital, the state, interlocking systems of oppression, social movements, and the components of the health care system.

Efforts to diffuse medication abortion to non-abortion providing physicians are the subject of Section III of this dissertation. After providing a summary about what is different about medication abortion, the results of an academic detailing study are presented. The initial aspirations that medication abortion would help diffuse the abortion wars by increasing the number of private physicians who offered it in their offices remains unfilled. Despite the limited success of the academic detailing project presented in this dissertation, addressing the abortion provision shortage will require a much more systemic approach. To make this change the "abortion is problematic" hegemony must be disrupted. Abortion will need to be seen as normal.

Depoliticizing abortion and developing an alternative understanding of abortion as just another type of health care, like appendectomy or tonsillectomy, or simply another decision women make, like going to law or medical school, seems impossible to many and morally reprehensible to others. Despite the lofty and contested nature of such a social "reframing," understanding how such an endeavor might occur serves as the focus of my future work. That is, I seek to challenge the hegemony of the idea that abortion is intrinsically problematic. The work conducted as part of this dissertation helped to develop an understanding of those aspects of abortion opposition and support that preclude such a radical transformation in the way in which abortion is understood both as a health care service and as a woman's decision. In my future work I seek to meet Gramsci's challenge and become an "organic intellectual" capable of articulating an alternative vision and bringing the subordinate class into the revolution.