

Ensuring Access to Safe, Legal Abortion in an Increasingly Complex Regulatory Environment

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Restrictions on access to abortion in the United States have reached proportions unprecedented since the nationwide legalization of abortion in 1973. Although some restrictions aim to discourage women from having abortions, many others impede access by affecting the timeliness, affordability, or availability of services. Evidence indicates that these restrictions do not increase abortion safety; rather, they create logistic barriers for women seeking abortion, and they have the greatest effect on women with the fewest resources. In this commentary, we recall the important role that obstetrician–gynecologists (ob-gyns) have played, both before and after *Roe v. Wade*, in facilitating access to safe abortion care. Using the literature on abortion safety and access as a foundation, we propose several practical ideas about what we as ob-gyns can do to address the current threat to abortion access, whether or not we provide abortion services in practice. We hope that this commentary will encourage discourse within our profession and prompt other suggestions. As ob-gyns who are dedicated to addressing health disparities and promoting the health and well-being of our patients, we can make a difference.

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Restrictions on access to abortion services in the United States have reached a magnitude unseen since the nationwide legalization of abortion in 1973.¹ According to the Guttmacher Institute, state legislatures enacted 288 new abortion restrictions from 2011 to 2015, which rivals the number adopted in the preceding 15 years (<https://www.guttmacher.org/article/2016/01/2015-year-end-state-policy-roundup>). Whereas some regulations, such as those mandating preprocedure ultrasonograms, aim to dissuade women from having abortions, many others, such as those that increase the number of visits, prohibit insurance coverage for abortions, ban common abortion methods, or impose overreaching regulations on ambulatory clinics (where 95% of abortions currently occur),² impede access by affecting the timeliness, affordability, or availability of care. For example, as of March 2016, 14 states require women to receive in-person, state-mandated information about abortion 24–72 hours before the procedure. Available research indicates that “waiting period” mandates have little influence on the abortion decision, but those requiring multiple visits increase travel and logistic burdens for women and delay care.³ In Texas, passage of a highly restrictive abortion law in 2013, part of which required local hospital admitting privileges for abortion providers, forced the closure of more than half of the state’s 41 abortion clinics. In the aftermath, a rapid decrease was seen in the state’s abortion rate,⁴ and women whose nearest clinic closed experienced substantial increases in travel distances and costs to obtain abortion services compared with women whose nearest clinic remained open.⁵ Although many regulations are touted as necessary to protect women’s health, accumulated evidence documents that abortions performed in ambulatory clinics are at least as safe as those provided in hospitals.⁶ Currently, nearly 60% of women of reproductive age reside in states that have four or more abortion restrictions; highly restrictive states predominate in



the South and Midwest, creating marked geographic disparities in access.

Restrictions on abortion access have a profound effect on women's health and particularly affect those women with the fewest resources.¹ Although women from all walks of life have abortions, those who are poor and low income experience disproportionately high rates of unintended pregnancy with the attendant consequences of abortion and unintended births.⁷ Studies have shown that women who decide to terminate their pregnancies may face numerous barriers, including difficulties raising the requisite funds, inadequate or inaccurate referrals, and problems reaching a health care provider.^{1,8-11} Attributable in large part to restrictions on federal funding and private insurance coverage of abortion, most women pay out of pocket for abortion care, and additional expenses related to travel and time away from work and family strain limited resources further.¹² These obstacles contribute to delay and compound the difficulties faced by women who need abortion services, particularly after the first trimester.^{8,9} Nearly all abortion providers in the United States offer services at 8 weeks of gestation, but only one third do so at 20 weeks of gestation, and the cost of the procedure increases as pregnancy advances.¹¹ Although modern induced abortion is exceedingly safe, abortion-related mortality and morbidity increase with gestational age.^{1,13} Denial of abortion services has other consequences too, as illustrated by the Turnaway Study, an ongoing longitudinal investigation that compares outcomes among women who obtained abortions and those who were denied services because they exceeded the facilities' gestational age limits.⁹ Compared with women who were able to obtain abortions, those denied were less likely to rise out of poverty or achieve 1-year aspirational life plans and more likely to continue in relationships marked by interpersonal violence.^{14,15} These data reinforce the recent statement by the American College of Obstetricians and Gynecologists (the College): "Safe, legal abortion is a necessary component of women's health care."¹

Both before and after *Roe v. Wade*, the 1973 landmark U.S. Supreme Court decision that legalized abortion nationwide, professional societies and individual physicians played pivotal roles in promoting access to safe abortion. In her illuminating book, *Doctors of Conscience*,¹⁶ Dr. Carole Joffe relates the stories of physicians in mainstream medical practices who were compelled by what they witnessed during the illegal abortion era to provide safe abortion care to their patients, even at great peril. Today, committed colleagues throughout the country continue to offer

abortion services despite stigmatization, harassment, arsons, bombings, and threats of injury and even death.¹¹ Numerous professional organizations, including the College,¹ have taken stances in support of abortion access and in opposition to regulations that threaten women's health and the sanctity of the provider-patient relationship. Mandates from the Accreditation Council for Graduate Medical Education and emergence of the Kenneth J. Ryan Residency Training Program have helped to integrate abortion training into residency programs, and family planning fellowships have produced a new generation of expert clinicians, researchers, and academic leaders in the field.¹⁷ Despite these diligent efforts, however, access to abortion is in jeopardy. As obstetrician-gynecologists (ob-gyns), what more can we do to address this threat to comprehensive reproductive health care?

Although a thorough analysis of this question is beyond the scope of this commentary, ensuring that women's health care providers have (or know where to find) accurate information about the rapidly changing regulatory landscape of abortion is a place to start. Evidence indicates that reproductive health practitioners are well informed about some abortion regulations but have misconceptions about others, which may result in unnecessary restrictions on practice or provision of misinformation to patients. For example, in a survey of clinician members of five U.S. reproductive health organizations, only 56% of respondents knew whether their states' Medicaid regulations permitted funding for abortion, and approximately 15% were not certain whether married women requesting abortion required spousal consent (a requirement that the U.S. Supreme Court has declared unconstitutional).¹⁸ Clinicians who reported receiving reminders about their states' abortion regulations (usually from someone in their practice) exhibited significantly greater overall knowledge than those who did not receive reminders. A study involving simulated patient calls to 46 abortion-providing facilities found that most frontline phone staff gave accurate information about their states' parental involvement laws, but only 58% informed the caller about the option of judicial bypass (a process by which minors can receive court approval for abortion).¹⁹ In a recent survey of U.S. members of the Society for Maternal-Fetal Medicine, 60% of respondents reported that their affiliated medical centers did not offer termination of pregnancy after 24 weeks of gestation for women whose pregnancies were affected by lethal fetal anomalies.²⁰ Of these respondents, two thirds cited state legal prohibitions as a reason for not offering these services, but 38% of these physicians were misinformed, that is,



they practiced in states that did not ban post-24-week terminations for lethal fetal anomalies. In addition, 8% of the respondents cited federal law as a reason, although the U.S. Constitution affords a woman and her physician the right to decide to end a nonviable pregnancy at any point in pregnancy. Greater dissemination of information about abortion regulations and legal resources through national and state professional societies could improve access by ensuring that patients receive accurate information and that health care providers of abortion care have the knowledge necessary to practice within the full extent allowed by law.

Because nearly all practicing ob-gyns encounter women requesting abortion but only 14% offer these services,²¹ health care providers and others involved in patient education or coordination of care (eg, counselors, frontline phone staff) should have accurate and timely information about abortion referrals. Research confirms that, in addition to cost and logistic barriers, difficulties finding a health care provider and other referral problems figure prominently in abortion delay.^{1,8,9} In one study, women presenting for abortion in the second trimester were four times as likely to report problems finding a health care provider compared with first-trimester patients, and they cited referral issues as the primary factor in delay.⁸ Although little is known about the ways women find abortion care, contacting physicians' offices for abortion referrals may not always yield helpful information. A recent report revealed that only 46% of calls to ob-gyns' offices in 11 states led to a direct referral (name and contact information of an abortion-providing facility); 9% resulted in an inappropriate referral (referral to a facility that did not provide abortions) and 27% in no referral at all.¹⁰ In a recent survey of women seeking abortion at Nebraska abortion clinics, only 30% had received a direct referral after contacting a clinician, and 64% received no referral.²² Resources exist to assist women and health care providers with abortion referrals, and some offer funding and logistic assistance as well (Table 1). Referral resources are available to College members through the College's Resource Center (resources@acog.org), and greater dissemination through other professional and community organizations and through clinical staff trainings would improve referrals and reduce delays for patients seeking abortions.

Departmental leaders in mainstream medical centers also can facilitate access by ensuring that abortion services (where they are offered) and management of complications (even where abortion is not offered) are integrated and respected components of care. Studies indicate that health care providers of

hospital-based abortion services may face numerous obstacles such as negative staff attitudes, unsupportive administration, logistic issues (eg, staffing problems, lack of operating room time), and restrictive hospital policies.^{20,23} To address these barriers, department chairs could hold meetings with their family planning and maternal-fetal medicine teams to explore whether and how these issues affect their practices and to brainstorm solutions. Where family planning services are marginalized in part because they are not self-supporting, departmental leaders could help family planning faculty develop funded research or educational programs or devise other ways for them to contribute to the activities of the department. Leaders also could support integration of family planning services through collaborative models of obstetric care. For example, women whose membranes rupture in the second trimester typically are evaluated in labor and delivery suites, where caregivers' primary focus is on optimizing the chance of delivering a healthy neonate (or neonates). In this circumstance, a team-based approach that involves consultations with both maternal-fetal medicine and family planning (and neonatology when appropriate) helps to ensure that women have the information they need to consider their options and treatment preferences. Many women prefer dilation and evacuation to labor induction as an abortion method²⁴; moreover, in certain situations, such as septic abortion after the first trimester, dilation and evacuation may be the safer option because it is faster and avoids the use of prostaglandin agents that can elevate temperature. Involvement of family planning providers increases the likelihood that this option is available. Finally, arranging adequate staffing for abortion care, including during "off" hours when urgent situations requiring uterine evacuation may arise, also would benefit from the guidance of seasoned leaders. Willingness of staff to participate in abortion provision often falls along a spectrum and may be influenced by how advanced the pregnancy is, the reason for the abortion, and other factors. Experienced leaders can help to balance respect for staff members' beliefs and preferences with the professional obligation to protect patients' health and well-being.²⁵ Ultimately, addressing these barriers will require institutional commitment to ensure that all health care providers function within an organizational culture of respect and that all reproductive health services are fully and similarly integrated and supported.

Finally, no commentary on abortion access would be complete without mentioning the responsibility of each of us to prepare the next generation of



Table 1. Organizations That Provide Abortion Referrals and Logistical Assistance for Eligible Women

Organization	Services	Contact Information
National Abortion Federation	Provides referrals to National Abortion Federation member clinics and has funds to support low-income women	Referrals to clinics: 1-877-257-0012; funding support information: 1-800-772-9100
Planned Parenthood Federation of America	Provides referrals to Planned Parenthood clinics and has funds to support low-income women	1-800-PLAN
National Network of Abortion Funds	Provides funding support to low-income women through a network of state-based funds	http://www.fundabortionnow.org/explore

practitioners to meet the reproductive health care needs of women, including family planning. Teaching students and residents about patient-centered contraceptive counseling and provision to prevent unintended pregnancies is a fundamental part of this endeavor. In the area of abortion, we can support the integration of opt-out training (routine abortion training with opt-out provisions for residents with religious or moral objections) in our residency programs, as required by the Accreditation Council for Graduate Medical Education and endorsed by the College.¹⁷ We also can support ongoing efforts to expand opportunities for nurse practitioners, certified nurse-midwives, and physician assistants to train and provide first-trimester medical abortion and suction curettage.¹ Whether or not we include abortion services in our practice, we can model professionalism by demonstrating the importance of respecting women's autonomy in decisions about pregnancy, even if they conflict with our own beliefs. We can teach students and residents how to counsel women about their pregnancy options and make appropriate referrals. Moreover, because increasing numbers of women travel long distances to obtain abortion services and then return to their communities, teaching trainees how to address the infrequent problem or complication that may occur also is critical. Whether we are specialist ob-gyns or subspecialists, we will care for patients who grapple with pregnancy options, many of whom will go to great lengths either to continue a pregnancy or to obtain an abortion. Although only some of us may choose to teach the "how" of abortion care, all of us can teach the "why" underlying women's decisions by giving trainees the opportunity to hear these women's stories.

As ob-gyns, we work diligently to meet the reproductive health care needs of women by offering safe, high-quality care and by advocating for policies that decrease disparities and promote our patients' health and welfare. Although abortion is mired in

controversy, it remains well within the scope of our professional advocacy. Approximately one in three women in the United States will have an abortion by age 45 years.^{1,2} Women decide to have abortions for many reasons, including that they cannot afford to have a child or another child, have work or educational responsibilities, or experience unforeseen complications or life events during pregnancy. A patient's decision about her options may differ with each pregnancy that occurs during the course of her reproductive years, depending on circumstances, and our professional obligation to protect her health and interests is no less compelling when she decides to terminate a pregnancy as when she elects to continue one. Although our opinions and practice preferences may differ, we still can engage in respectful dialogue and work collaboratively to facilitate the best treatments and referrals for our patients. We can assist our patients' efforts to prevent unintended pregnancies by encouraging reproductive life planning and offering contraceptive information and provision that aligns with their needs, values, and preferences. We can support public funding of family planning services and other policies that address the inequities affecting women's agency and access to care. Ultimately, moving abortion from the margins to the mainstream of women's health care and ensuring that all women have access to comprehensive reproductive health care services will take many hands and many voices. In both large and small ways, we ob-gyns can make a difference.

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