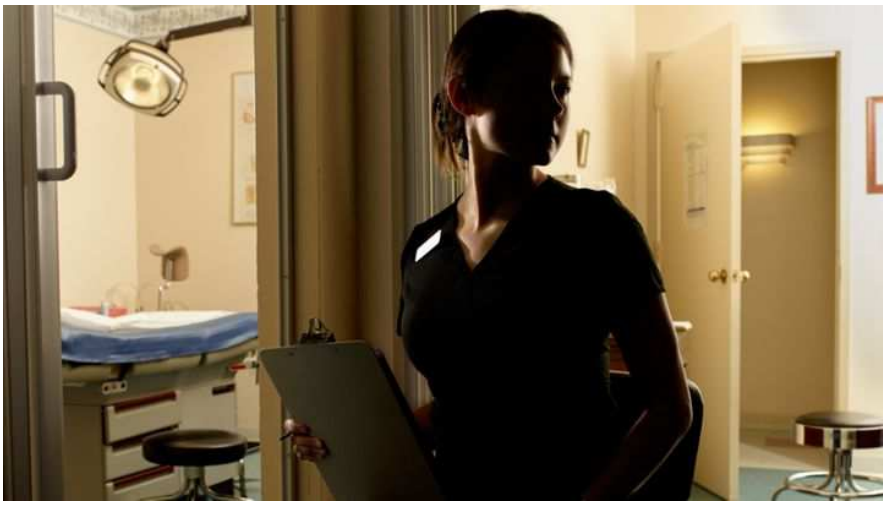
An Abortion Provider Speaks Out: 'I'll Do Whatever My Conscience Tells Me I Must'

Dr. Cheryl Chastine discusses the recent attacks on Planned Parenthood, and why she provides abortions, despite threats and harassment

BY ANDREA GRIMES | November 24, 2015



"I make those sorts of calculations every day," Dr. Cheryl Chastine says, of considering her safety before telling strangers she provides abortions. Saverio Truglia

By now, most of the right-wing investigations into Planned Parenthood's fetal tissue donation practices — spurred by a series of heavily edited, deliberately misleading videos produced by a right-wing anti-abortion fringe group — have wrapped up. Investigators turned up no wrongdoing. But Texas Republicans are still pursuing a highly public campaign against the group, with the state attempting to boot Planned Parenthood from the federal Medicaid program.

SIDEBAR

Meanwhile, in the GOP presidential primary, candidates are attempting to out-extreme each other on their stances against abortion, leaning heavily on the aforementioned videos as evidence that nefariousness is

Planned Parenthood Is Not Harvesting 'Baby Parts' »

provider's office.

So Rolling Stone decided to ask one — an actual abortion provider, not a pundit or a politician — about all this. Dr. Cheryl Chastine is a Chicago-based family physician who provides abortion care. Here, she talks about why she decided to specialize in abortions, the maddening trend of dismissing abortion providers' medical expertise as political bias, and what the upcoming presidential election could mean for abortion rights.

Why, and when, did you decide to become an abortion provider? And what kinds of challenges did you face — personally, professionally — in doing so?

I didn't go to med school thinking I wanted to provide abortions. I'd always been politically conscious, though, so I worked with some fellow University of Kentucky students to start a chapter of Medical Students for Choice (MSFC). I figured we ought to have one. But I had no real intention of providing abortions myself.

Medical Students for Choice made a new connection for me: for abortion to remain a meaningful option, we need doctors who are trained and willing to do them. With the providers at the time aging and retiring, I realized, there would be people who would need abortions and not be able to have them, unless I stepped up.

Given that abortion is such an incredibly common and safe medical experience — 1 in 3 people who can get pregnant will have at least one — it's amazing and appalling how marginalized it is in most areas. We didn't cover it in my medical school classes, although we spent countless hours on rare genetic diseases. I wouldn't have been taught during my family medicine residency, if I hadn't had the connections via MSFC to seek it out independently. And when you go into practice, even as an OB-GYN, the default assumption is that you won't provide abortions.

I was practicing family medicine in the Chicago area when I heard from a woman who was looking to connect clinics with trained providers who were willing to travel. I figured I could do that occasionally and use my training, as planned, to provide abortions for people who wouldn't be able to access them otherwise. The first clinic director I heard from, though, was trying to open a new clinic in a very high-profile, hostile area. So once the national anti-abortion domestic terrorist

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will shoot the new provider...").

The local group started picketing my family medicine practice and calling the building's owner, bargaining that I would stop providing abortions. They made it their mission to make it impossible for me to do family medicine and also provide abortion care.

I wasn't about to let awful tactics like that work, because that would just encourage them to keep doing that to others. So the ultimate effect was that I became a full-time provider of abortion care.

I have no regrets about my path. This is even more important, and more rewarding, than I'd thought it could be. Every day I go to work, I can make it possible for someone to leave an abusive relationship, care for their children, continue their education, deal with an illness. Every day, my patients hug me and thank me and tell me I've helped them get their life back.

Dr. Cheryl Chastine Saverio Truglia

What are the logistics of abortion provision like for you in 2015?
My provision of abortion care is circumscribed by a number of restrictions that have nothing to do with safe, high-quality abortion care. The most degrading to the patient is a state-mandated waiting period. The patients who come to me for abortion care have already carefully considered their decision, usually before they even make their appointment. Requiring them to leave and come back is incredibly condescending. As I phrase it to the patients, "I would love to take care of you today, but your state lawmakers think that you haven't thought about your decision." Of course, the requirement is really designed to increase the chances that the patient will be unable to access the

family member will get sick.

Thanks to abortion stigma and violence, we now live in a country where there's not only a shortage of doctors who have the necessary training, but a mismatch between where trained providers live and where services are most needed. The doctors who provided abortions in the years around Roe v. Wade were already embedded in their communities, and they began providing abortions out of a sense of duty to the people of those communities. Once abortion became legal and the need was not so desperate, though, this community-based urgency let up.

Given how much abortion stigma has mounted since then, and how much more difficult it is now to learn something mid-career, you don't become an abortion provider unless you decide before you finish med school that you're going to do it. In most cases, you have to fight to get training. If you have to do that, you know you're going to be putting yourself on the line. So now, the only people who become providers are ones who start off ideologically committed to abortion care. Understandably, those physicians are hesitant to then make their homes providing abortions in actively hostile environments.

So do you travel to provide care then?
I live in Chicago, which has a surplus of abortion providers. My skills aren't essential there. So to provide abortion care to the patients who need it most, I travel to where the need is. Being based in Chicago means I'm within a couple of hours' travel of almost anywhere in the continental U.S. I travel to communities whose providers have retired and not been replaced, or have been forced out of doing the work, or have been murdered.

SIDEBAR

How Abortion Providers Are 'Living in the Crosshairs' »

Do you feel safe talking about what you do in casual conversation?
In American culture, work is such a big part of who we are that "What do you do for a living?" is an incredibly common small talk question. So with every encounter like that, I have to decide whether I want to bring it up. Should I say, "I provide abortions," to my airplane seatmate? My hairdresser? The woman on the treadmill next to me at the gym? I don't want to perpetuate abortion stigma by not talking about it, and I'm proud as hell to do what I do. So I usually talk

act.

At the same time, though, you never know who might be anti-abortion. Now, I'm not worried about upsetting anyone. But I do have to think about whether, say, my hairdresser might call up the groups that harass me and tell them where and when I go there. Then I have to worry that they might start picketing my haircut appointments, or calling the salon and threatening to boycott or protest them if they continue seeing me, or even that at my next appointment there could be someone waiting outside with a gun.

It's absurd and appalling that I have to think about that. But I make those sorts of calculations every day.

Many medical professionals have weighed in on the Planned Parenthood videos and related subjects. Yet somehow the media continues to treat anti-abortion lawmakers, lobbyists and activists as authorities on the subject of abortion and fetal tissue donation. What's it like to be an actual medical expert, only to find your voice drowned out by ideologically driven politicians?

Somehow, anti-abortion activists have succeeded in convincing the general public that abortion providers are not to be regarded as experts on abortion. The claim is that providers' status as providers somehow makes us suspect or biased. It's implied that we can't be trusted. This is simply bizarre and without precedent in the medical world. Infectious disease specialists are regarded as being experts on infectious disease. Cardiothoracic surgeons are regarded as experts on what is safe and necessary for open-heart surgery. Ear, nose and throat surgeons are regarded as appropriate conductors of high-quality research in their own surgical field.

I've dedicated my career and my life to the provision of safe, high-quality abortion care. It's infuriating that my judgment is considered irrelevant by politicians and activists who know absolutely nothing about the provision of abortion care. Underlying the anti-choice legislative approach to abortion care is the presumption that abortion providers aren't interested in providing safe care, but rather want to provide the lowest standard of care that we can get away with. That's no more true for us than it is for any area of medicine. We should be regarding anti-choicers' perspective on abortion safety as the suspect one, since they find all abortion care unacceptable regardless of its safety. Given that, they are broadly unwilling to acknowledge the basic safety of abortion.

and has coerced them into donating fetal tissue in order to generate profit. (The group announced in October it would no longer accept reimbursement for fetal tissue donations.) Is there any universe in which a conspiracy of this size would be plausible? Is that really how doctors, OB-GYNs and abortion providers think?

Planned Parenthood's standards for its affiliates include the provision of nondirective counseling [counseling in which the doctor or counselor does not provide advice] to ensure the patient is making the best decision available to them. The National Abortion Federation also specifies nondirective counseling. Every clinic I've seen also directly screens for the presence of coercion by a family member, partner, etc. The truth is that the vast majority of patients come in for their abortion appointment with their decision already firm. Patients who feel uncertain are readily identifiable. We guide them through their options, and a patient who seems genuinely undecided is encouraged to reschedule, or simply referred for prenatal care if they are clear on not wanting an abortion.

Physicians are bound by bioethical standards, including nonmaleficence, beneficence and respect for patient autonomy. Given the huge number of medical professionals who have worked through Planned Parenthood, and the huge number of patients they care for, it is beyond belief to suggest that a broad pattern of coercion would go unchallenged and undocumented.

Patients regularly request, unsolicited, to donate their fetal tissue. Often, they find it comforting to think that someone else may be helped as a result of their abortion experience.

A family member of mine had appendicitis recently and underwent an emergency appendectomy. His adjusted hospital bill was around $18,000. He received separate bills from the pathology laboratory, for handling his tissue specimen, and from the pathologist for examining the prepared specimen, each totaling several hundred dollars. He additionally got separate bills, each for several hundred dollars, from the emergency room physician, the radiologist who read his CT scan and the hospital laboratory. The operating surgeon billed thousands of dollars. Given those numbers and similar ones throughout medicine, it's absurd to claim that abortion, at $500 or even $2,000, is going to create outrageous wealth, or that $30 or $100 for fetal tissue is an amount significant enough to affect the abortion care the patient receives.

For people who work in abortion, whether it's physicians or clinic staff,

would pay me better and let me avoid dealing with a constant onslaught of harassment and stigma. I work in abortion care because I love caring for the patients who need me the most; there's no other reason to do this work.

Anti-choice advocates often point to "bad apple" abortion providers to paint the procedure as broadly unsafe. How safe is abortion, actually?

Abortion is extremely safe. A 2012 study published in the Journal of Obstetrics and Gynecology showed an overall mortality rate for abortion 14 times lower than the mortality for childbirth. Texas consistently has many more deaths from childbirth than from abortion each year — far more than can be attributed simply to the greater number of births. All of the much-hyped risks of abortion are actually more likely to happen with a vaginal delivery at full term.

What are you hearing from your colleagues about how the attacks on Planned Parenthood are affecting them and their practices?

Among my colleagues, I think we're really concerned because it's so clear that this is a politically motivated witch-hunt. It's a pretext to launch further attacks on providers of safe, legal abortion care. As a community, we already feel like we're under siege, what with the onslaught of indefensible new regulations since 2010. Even for those of us who don't work for Planned Parenthood, the message is clear to us that we're next. If Planned Parenthood is forbidden to receive Medicaid reimbursement, then the rest of us who provide abortion care can also expect to lose our Medicaid practices. The main losers in that scenario are poor Americans. So for us as providers, we know this just heralds further baseless state intrusion into our patient care.

Are the anti-Planned Parenthood videos having an effect on your patients?

I don't think our patients have been significantly affected. It hasn't seemed to affect the flow of patients or the concerns they raise. To me, that really shows just how irrelevant all this grandstanding is to the actual people who find themselves in need of abortion care.

Looking forward politically, what do you see, or hope not to see, coming from lawmakers with regard to abortion care? What does the 2016 GOP (or Democratic) field hold for the future of what you do?

For the past several presidential elections, I've believed keeping abortion legal and accessible depends on electing a Democrat. There are four liberal justices on the Supreme Court, plus Kennedy, the swing

conservative, and that will effectively overturn Roe v. Wade and end abortion access in most of the U.S.

You can bet anti-abortion strategists know that, too. But I'm pretty sure the country at large doesn't. And most people don't really think about abortion access until they need it themselves. American moralizing about sex turns into prudish discomfort and disapproval of abortions and the people who need them. But when they themselves have a pregnancy they can't continue, they're distraught about all the things they might have said were reasonable before: forced ultrasound viewing, demeaning waiting periods, biased or false "information," unconstitutional gestational limits, expensive and irrelevant facility upgrades.

Texas is often seen as a "test case" for whether extreme abortion restrictions can pass constitutional muster, so we're keeping a close eye on what the Supreme Court does next summer. What could happen if Texas' abortion restrictions are validated by the high court?

Coming up, I expect we'll see more of the "incremental" restriction strategy that's worked so well up to now. If "fetal pain" is upheld as grounds for restrictions, we'll see it imputed to earlier and earlier gestations, with accompanying bans. We'll see more bans on specific reasons people have abortions, for reasons of any fetal diagnosis, for rape or incest, for health conditions that are deemed too "trivial" to be an abortion indication. We've seen bans on intact D&E and now on all D&E [a common abortion procedure –what anti-abortion lawmakers inaccurately refer to as "partial-birth" abortion] so next we'll see bans on fetocidal injection, then on labor induction, so that there is no remaining legal technique for second-trimester abortion. We'll see more restrictions on who can provide, and more requirements for relationships with hospitals, backup doctors and labs that will increase the number of potential targets to shut down clinics.

If the Supreme Court rules against providers in Whole Woman's Health v. Cole, then every hostile state will implement the most stringent requirements allowed by the decision, then pass more laws targeting the few clinics that survive. That's why, as admirable as it is that a few clinics are planning to build ambulatory surgical centers in case these laws are upheld, I think it's ultimately fruitless. The legislatures are going to keep moving the goalposts until either the Supreme Court stops them, or every abortion provider is shut down.

If abortion access vanishes again in most of the United States. I think we'll see three things. First, there will be more clinics like the Whole

travel and pay for their abortions will have to expand and get patients distances. Second, we'll see a huge spike in the number of pregnancy terminations — self-induced and performed illegally. Some of those will be safe, and some won't. Third, just like before Roe, people who have money and social capital will be able to safely terminate their pregnancies. The burdens of unwanted childbearing and unsafe abortion will fall heaviest on poor, rural, black and Latino/a people.

As for me? It's my mission to care for these patients. I'll do whatever my conscience tells me I must.

Topics: Abortion | Planned Parenthood

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