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CALL ME IN THE MORNING

I'm an Abortion Provider and It's Time To Tell the Truth About Abortion in Later Pregnancy



Meera Shah
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MorningCall Me in the Morning is Jezebel's sexual health column.

New York passed the Reproductive Health Act (RHA) in January, legislation that will safeguard reproductive health access in the event that the Supreme Court were to overturn *Roe v. Wade*. As a physician who provides abortions in New York state, I was thrilled to learn that access to reproductive health will be preserved for my patients and I hope that other states follow suit. Though physicians like myself and reproductive rights advocates celebrated the passage of the RHA, there has also been plenty of unnecessary outrage fueled by misrepresentation over what the bill actually does, as well as abortion later in pregnancy.

During Tuesday night's State of the Union, Donald Trump repeated some of the worst myths about late abortion and the RHA. "Lawmakers in New York cheered with delight

upon the passage of legislation that would allow a baby to be ripped from the mother's womb moments before birth," Trump said. He then asked Congress to pass "legislation to prohibit late-term abortion." ("Late-term abortion" is not a medical term, and was invented by anti-abortion activists to confuse, mislead, and increase stigma.)

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What Trump said grossly mischaracterized what the RHA does. Passed on the 46th anniversary of *Roe v. Wade*, almost 10 years after it was first introduced, the RHA ended an almost 50-year history of the state including abortion in its criminal code, rather than treating it as a medical procedure. The vast majority of abortions occur in the first trimester, prior to 12 weeks, and about one in four American women will have an abortion in her lifetime. Most people who need an abortion are already mothers or their contraceptive method failed. A procedural abortion is a safe, quick in-office procedure with a less than one percent complication rate. A medication abortion involves a pill that ends the pregnancy followed by a few more pills that cause expulsion of the pregnancy. I see patients of different personal and religious beliefs, it's their unique life experiences bring them to the decision to have an abortion. We should honor and respect their decision.

***ABORTION LATER IN PREGNANCY
IS NOT WHAT PATIENTS
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The RHA now ensures that people in New York will have their constitutional right to an abortion; that includes the right to abortion after the 24th week in pregnancy if the pregnant person's life or health is threatened by the pregnancy, or if the fetus has a condition incompatible with life. Prior to this legislation, I have had patients find out about a fetal anomaly who then had to travel long distances to other states to get the care

they needed. Abortion later in pregnancy is not what patients anticipate for themselves; it's not how they see their pregnancies unfolding. I had one patient who couldn't afford to travel outside of the state and so she continued the pregnancy and the baby died shortly after birth due to a brain malformation. Years later, she is unable to tell her story without tears.

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Abortion later in pregnancy is not common, and this law will *not* make it more common—just more accessible. The RHA *does not* mean that abortion after 24 weeks is permissible for any reason, despite how some conservative lawmakers have characterized the legislation. The circumstances that lead to late abortion are unique are often times very difficult for my patients. My job is to treat them with compassion. We should all treat patients like this with compassion instead of criminalizing them.

A similar bill in Virginia introduced by Delegate Kathy Tran faced immediate and intense backlash fueled by ideology rather than facts. Political opponents argued that Tran, as well as Virginia's governor, Ralph Northam, who favors the bill, supports infanticide. Trump reiterated that charge during the State of the Union, saying that Northam would “execute a baby after birth.” But that simply isn't true. (Many are currently calling on Northam to resign after a photograph of him wearing blackface was reported on by *The Virginian-Pilot*.)

The bill would have done a number of things to improve access to abortion care. The bill also would have eliminated ultrasound requirements and waiting periods prior to receiving an abortion. They are both manipulative and unnecessary tactics that make it harder for people to get abortion care. Being forced to get an ultrasound, view ultrasound images, or have the ultrasound described to a patient does not dissuade patients from continuing with the abortion. Instead, they risk causing more distress to the patient. A 2017 study that looked at patients in Wisconsin found that “women seeking abortions overwhelmingly go through with the abortion, even when required to view the ultrasound image before the procedure.” Similarly, mandatory waiting periods are not based on medical evidence either. They only cause delays in care and significantly burden patients.

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The Virginia bill also would have removed the requirement that second-trimester abortion care be provided in a hospital, a requirement that is also completely unnecessary because second-trimester abortions can be provided safely in an office setting. Virginia has long had an additional needless requirement that not one, not two, but *three* physicians certify when a person needs a third-trimester abortion to preserve their health or life. This bill would have changed that number to one, trusting the pregnant person and their doctor's decision. Regardless, the Virginia bill has also been mischaracterized.

In addition to guaranteeing constitutional rights of citizens, the RHA also allows licensed, advanced practice clinicians (APCs) like nurse practitioners, physicians' assistants, and nurse-midwives to perform abortions. Contrary to some claims, this does *not* mean that any medical professional can provide abortion care. This means that licensed professionals who are not physicians can be trained to provide abortion care if it is within the scope of their practice. There is strong data from California showing that APCs can safely provide abortion in early pregnancy, and several states already allow APCs to provide first trimester abortions. Ensuring that APCs can provide abortion care to their patients will improve access, especially because APCs are often key providers of clinical care to underserved patients. It is my hope that other states see the importance of allowing APCs to provide abortions and pass similar legislation.

***AS A PHYSICIAN AND AN
ADVOCATE FOR MY PATIENTS, I
COMMEND NEW YORK FOR
PASSING THE RHA***

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And finally, something that hasn't received as much attention as it should, is that the RHA removed New York's antiquated law that makes it a crime to self-manage an abortion. New York was one of only seven remaining states that had such laws on the books, and in at least one of those states, a court recently found that law unconstitutional. Removing

those laws in New York ensures that people who take steps to end their own pregnancies will not be isolated from any follow-up care for fear of being arrested.

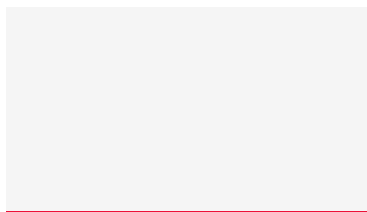
As a physician and an advocate for my patients, I commend New York for passing the RHA. It was long overdue and will finally expand and improve access to medically necessary care. My patients have unique lives and circumstances that bring them to the decision to have an abortion, and it is my job, as a physician, to trust them and to support them. I am grateful to visionary lawmakers like the sponsors of the RHA and to Kathy Tran for recognizing that abortion access is in danger and taking steps to protect their constituents. I urge other states to do the same.

Dr. Meera Shah, MD, MPH, MS is the Associate Medical Director of Planned Parenthood Hudson Peconic in New York and a fellow with the Physicians for Reproductive Health.

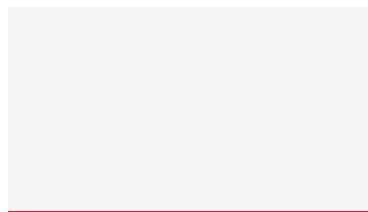
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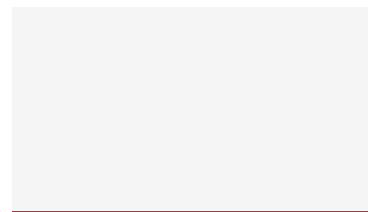
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