Listen to this story
--:--
28:56

YOUTH NOW

The Future Abortionists of America

Abortions are simple procedures, yet fewer than 0.2% of U.S. doctors perform them. Meet the new guard trying to improve access for all.

Malcolm Harris Follow
Sep 4, 2018 · 18 min read ★

Art: Claire Merchlinsky

A sign in the lobby of the Philadelphia hotel read:

> *THERE ARE NO EVENTS SCHEDULED FOR TODAY*
> *Please enjoy your day!*

Meanwhile, in the ballroom upstairs, a significant portion of America's current and future abortion providers were eating breakfast. The fake-out sign was one of multiple security measures, but the atmosphere at the Medical Students for Choice (MSFC) national conference still hummed with energy. Over the course of a day and a half, 450-plus medical students tried to absorb as much information as possible about providing abortions, information that—depending on where they go to school—can be extremely difficult to get. The vast majority of attendees were women in their early twenties. When the organization's executive director Lois Backus announced that one of the two men's rooms would defect for the weekend, an involuntary cheer passed through the audience, followed by laughter.

There are approximately 1,700 abortionists working in the United States—about the same number as active NFL players, and a small fraction compared to the 10,000-plus orthodontists. Because abortion reporting isn't mandatory in all states, exact numbers on procedures performed aren't available, but most estimates put the current annual total between 650,000 and 750,000. The rate works out to more than one procedure per day, every day of the year, for every single provider, and it's not equally distributed among those 1,700 doctors. Though most abortions are simple procedures, national capacity is stretched, representing yet another threat to U.S. abortion access at a time when state laws are increasingly chipping away at reproductive rights. In 2017, more abortion restrictions were enacted at the state level—doctors and advocates call them TRAP (Targeted Regulation of Abortion Provision) laws—than in the entire previous decade.

However, the paucity of abortion providers is not simply a function of the war on choice. Attacks on doctors have slowed as the anti-abortion-rights movement switched tactics from terrorism to legislation, and public approval has stayed relatively constant since *Roe v. Wade*, with around 80 percent of Americans in favor of legal abortion in some or all cases. The lack of providers is due in large part to the series of obstacles placed between medical students and the profession, which is the raison d'être for MSFC. It's the org's job to guide students under, over, around, and through those barriers. The hope is that these students will become the providers, teachers, and administrators who will

make the process easier for the doctors who come after them—and for the patients they serve.

> Medical schools, students, hospitals, and individual physicians, on the whole, simply avoid anything to do with abortion.

Nationwide, students at over 150 med schools are organized in campus chapters of MSFC, where they support and train each other in an extracurricular fashion, as well as lobby their schools for resources and for abortion to be incorporated into standard syllabi. At the annual conference, organized by the small Philadelphia-based national office, students from around the country meet to steel their collective resolve and to learn. The conference featured more hours in abortion training—theoretical and practical—than many attendees will ever receive in medical school.

. . .

Although they were nearly all progressive young women, the attendees had the kind of racial and regional diversity that's hard to achieve without intention. Unusually for this kind of event, students from elite schools were proportionally represented, which is to say they were nearly absent. Universities are concentrated in East Coast cities, but those students don't have the most to gain. A large number came to the conference from areas in the South and Midwest, where authorities at every level are hostile not only to abortion and abortionists, but to abortion education of any sort, even for doctors. One group was from a public university in a Southern state where doctors who perform second-trimester abortions are flown in from around the country for a couple days of work at a time and then flown home.

Most of the students I spoke with had biology or science backgrounds, but E* started out studying music, a story that surprised her classmates. What changed? "Tiller," she said, referring to the 2009 assassination of Kansas abortion provider Dr. George Tiller. "I went to the vigil and carried a candle, and I knew that what I felt then was more intense than

anything I'd felt singing. When I got back to school, I changed my major to sociology/women's studies and started volunteering at Planned Parenthood."

One of her classmates asked, "Did you write about it on your application?"

E nodded shly, and there were murmurs. "You're not supposed to do that," she explained to me. It's a public school, but the faculty is known to be religious and anti-abortion-rights. Her admissions interview was with an old Catholic doctor. Though it was the centerpiece of her application, he never brought it up.

For two decades after *Roe*, the number of residency programs for obstetricians and gynecologists—the medical specialty where most abortionists train—that included abortion instruction declined steadily, until 1996 when the American Council on Graduate Medical Education (ACGME) began requiring access to abortion-training as part of residency accreditation.

Though the requirement halted the decline, there's little evidence it has been meaningfully implemented. An ACGME clarification issued in June 2017 stated that, due to moral/religious opt-out provisions, no students necessarily had to *receive* abortion education in order for programs to be in compliance. In the most recent national survey of medical schools on the topic (2005), only 19 percent reported a single preclinical lecture on abortion, and two-thirds reported no knowledge of any formal abortion education at all in the first two years of instruction. Only 10 percent of third-year OB/GYN clinical rotation programs reported any clinical abortion experience (think, a field trip to Planned Parenthood), in which most students participated.

> There are approximately 1,700 abortionists working in the U.S.—about the same number as active NFL players.

By making abortion education optional, schools, legislatures, and regulatory bodies have ensured that most time-crunched medical students won't bother to participate. It's part of a larger pattern wherein medical schools, students, hospitals, and individual physicians, on the whole, simply avoid anything to do with abortion—partly to dodge

TRAP laws, partly because the whole issue is taboo, and most of all because they can. If the state legislature doesn't approve of abortion, there's a good chance the state medical school doesn't either.

That's the case where E goes to school. "My husband owns a business there, so all my eggs were in one basket," she said. E could become the kind of provider her community needs—a local one who can perform abortions on a regular basis—but to do it, she would probably have to live elsewhere first. At her public university, abortion education consists of a single one-hour optional lecture about the procedure. (I asked if this common, if there are a lot of *optional* lectures in medical school and got a table full of blank looks.) To find a residency where she could train to competency in abortion, E would almost certainly have to go to another region.

E and her classmates know the handful of providers in their state by name, and for a moment, they imagined upcoming retirements, future job openings, clinics they could run someday. None of them was sure they'd be able to make it work, including E.

. . .

Like any other professional coterie, abortionists have their own lingo. OB/GYN is not pronounced in the civilian way, where it's spelled out, but shortened by a syllable to *oh-bee-guy-n*. Some of their other choices are more consequential: "products of conception" is the term for what is removed from the patient's uterus during an abortion. It sounds euphemistic, but it's also medically accurate, unlike "fetus," which doesn't develop until around the 10th week of pregnancy. "Antis" are the self-described "pro-lifers," a term these medical doctors decline to use. "Provider" is the default name for doctors who perform abortions. For providers who began "the work" during or in the wake of prohibition, "abortionist" suggests not just the exclusive practice thereof, but a dirty aura of unprofessionalism, danger, and exploitation.

For a new generation of providers, however, it means something different: an overriding political commitment to health care. As Dr. Rebecca Mercier, an abortion provider and professor at Jefferson University Hospital in Philadelphia, told the students, "Some people don't like the term 'abortionist'… But I kind of do."

MSFC bills its provider panels as the "most popular sessions," and it's easy to see why. These sessions gather four doctors each, and they tell stories, answer miscellaneous lifestyle questions, and flex a particular kind of bravado. At the one I attended, three of the doctors took turns holding the infant daughter of panelist and clinical fellow at the University of Pennsylvania Dr. Sarah Horvath, soothing her without slowing down the lightning question and answer session.

The message was implicit but clear: With the support of your professional community, you can be an abortion provider and live whatever life you imagine—including being a parent yourself. The panelists may have been preaching to the choir, but how else to recruit? Their bottom line was encouragement, and the audience soaked it up.

On the panel, behind closed doors, the providers could violate taboos around their profession and, in doing so, bring students one step closer to the inner sanctum. "We can be self-censoring sometimes," Mercier lamented, "because we are so *vulnerable*. When we talk to the public, we default to the 'MSPs,' the 'most sympathetic patients.'"

If they were to voice their doubts or speak about more complicated cases, providers would risk falling into a series of traps built by their opponents. When they reveal details — even in an effort to destigmatize the procedure—antis paint the grossest particulars on protest signs. When they criticize their industry's practices or history—or even allude to the existence of an "abortion industry"—they find their own words waved at them like weapons. At the conference and on the panels, the providers don't have to round their corners. They tell complex truths without seeding harmful lies. "The first time I saw an abortion, I passed out," Horvath said.

> Without Medical Students for Choice, students might find themselves learning how abortions are performed from YouTube.

Emily Young, a doctor from Charlottesville, Virginia, reassured students that as providers, they would not have to live in daily fear; they could be both the doctor on the block and an abortionist. Simply by virtue of being themselves and doing the work, they

would be advocates. “Everyone knows I’m the abortion provider in Charlottesville,” she said, “and I like that.”

Horvath agreed, saying that by doing abortions in addition to a full-range of medical practice she hopes to normalize it. Medical students want to be doctors, and the roomful seemed happy to hear that performing abortions would not automatically forfeit all the benefits and prestige of being a doctor. There was a relieved sigh when the audience heard that psychiatrists are more likely to be murdered in the course of their work than abortionists are.

Most of the conference attendees I spoke with were considering providing abortions once they become MDs. They were also planning on advocating for abortion access wherever they end up in the health industry, and they viewed the medical training as a necessary part of a comprehensive education that they were willing to go out of their way to obtain. A smaller number of people were there because they had decided to become abortionists. They talked differently than their peers, and I got the sense they wanted to fast-forward through parts that weren’t relevant to them, the parts they were supposed to find convincing. They were the already convinced.

“It’s the first line in my Tinder bio,” said K, a local student set on becoming a provider. “If a guy can’t handle that, then he can’t handle me.”

. . .

The med students found their rockstar in Andrea Chiavarini, a doctor who flies to Kansas or Oklahoma from her Portland, Oregon, home twice a month in what she called “high-volume abortion care travel.” Chiavarini had come to the conference directly from the South Wind Women’s Center in Wichita—otherwise known as “Tiller’s clinic”—where she provides as much second-trimester care as is legal in the state. Martyr’s shoes are a heavy inheritance, but Chiavarini wears them well. The child of a conservative religious family in east Tennessee, Chiavarini moved to Portland because “that’s what you did in the early ’90s if you were a weirdo and you couldn’t afford New York or San Francisco.” Unlike the generation that mentored her, Chiavarini went from politics to abortion to medicine, rather than the other way around—a path more common among the conference students.

As a 20-year-old socially conscious college dropout, Chiavarini was drawn to the abortion rights movement and began volunteering at the Portland Feminist Women's Health Center. (At the time, abortion clinics nationwide had recently weathered a serious wave of violence; the Portland Center narrowly avoided an incendiary bomb in 1985.) "I thought they were going to have me answering phones or something," Chiavarini told me. "But they trained me as a health care worker. At first, I took care of women after they had abortions, in the recovery room. Then I learned how to sterilize instruments, analyze tissue, do ultrasounds. It turned out I loved medicine."

Chiavarini looked into a career in public health advocacy because she thought of herself as an activist first. She even considered law school. Then, a friend—a founder of the Eugene Feminist Women's Health Center—sat her down. "'You are a surgeon. This is what you need to do,' she told me. And she was right." Chiavarini went back to school at Portland State, pre-med this time, rather than theater. At Oregon Health & Science University, Chiavarini took a leadership role in the nascent MSFC.

Living in Portland gave Chiavarini a front-row seat to the life-and-death struggle for abortion rights. In 1992, Rachelle "Shelley" Shannon tried to burn down the Eugene Feminist Women's Health Center; a year later, Shannon shot Tiller twice in a failed assassination attempt at his clinic. (Tiller returned to his practice and was assassinated by another right-wing terrorist, Scott Roeder, while attending church in 2009.) Chiavarini attended Shannon's trial, as well as a civil trial against the publishers of the infamous "Dirty Dozen" poster, which listed the names and addresses of 12 providers, two of whom were subsequently murdered.

"I got to see doctors standing up for themselves, and I've carried that with me," Chiavarini said. "It allows me to walk into Tiller's clinic, where he was shot, and say, 'Yes, I will do abortions here.'" Chiavarini is fun and morally serious, not in turn, but at the same time. I overheard students whispering about her all weekend.

. . .

Many students come to the conference in need of practical instruction. Depending on their university and their residency, without MSFC, medical students might find themselves stuck learning how abortions are performed from YouTube. On the

conference's second day, it offered two-and-a-half hours of intensive instruction broken up into first and second trimester sessions, for the attendees who needed it. Chiavarini, with her hyper energy and theater background, presided over the first overview. "Trigger warning!" she announced too late as the image slid in. "Whoops! Anyway, those are fetal parts." Humor is one of Chiavarini's ways to shock the students a little, to get them thinking less like civilians. She tells jokes that would make most people blanch.

Because knowledge about the uterine reproductive system is taboo even within medical schools, it was hard for Chiavarini to know where to start. She quickly glossed the curiosities of what the "first trimester" even means. For laymen, the math seems easy: nine months, three trimesters, three months each. But doctors measure pregnancy from the first day of what they call the last *normal* period. The first trimester lasts 13 weeks, but by the first day of the first missed period, the official count is already at four. To an uninformed public, the confusion around this measurement could imply that patients have taken longer to seek out treatment than they actually have. It also means that abortion bans based on weeks are counting days prior to conception.

Chiavarini explained the different procedures for medication abortion and surgical abortion to the full and rapt conference room. The medication regimen she recommended involves doses of mifepristone and misoprostol, which together block progesterone ("Pro-gestation, get it?"), dilate the patient's cervix, and induce uterine contractions that expel the products of conception. As an instructor, Chiavarini consistently acknowledged—then sliced through—the thin film of embarrassment that covers the subject, even for med students.

Patients might prefer medication abortion for the sense of control, Chiavarini said, or because they can expel the products of conception in the relative comfort of their own homes. Still, medication abortion requires patients to return to their provider and undergo an ultrasound to make sure all tissue has passed from the uterus.

If patients are coming from out of town—which is common, since 9 out of 10 counties in America lack their own providers—a surgical procedure is a safer and more efficient choice. Chiavarini told the story of a college student who had an incomplete medication abortion and, unaware she was still pregnant, returned to campus. She didn't get to the clinic until a day before her state's 22-week ban would have forced her to bring the pregnancy to term. Chiavarini performed what should have been a two-day procedure in

the legally available one day. She cited this as an example of the "flexibility" required by the job.

To begin a first-trimester surgical abortion, the provider administers a paracervical block, which is two painkiller shots into the cervix. "Vaginas are not sterile," Chiavarini reminded the audience as she demonstrated her "no-touch" technique for handling the metal dilators (small rods with the ends tilted at angles and tapering to different widths), flipping one between her fingers laterally to access either side. Passing the dilators around, the attendees mimicked her movements automatically.

After the provider dilates the cervix, they insert into the uterus the cannula, a rigid or semi-flexible plastic tube averaging around 10 mm in diameter, which is narrow—the size of a pearl, significantly smaller than a dime. In the first six weeks of a pregnancy, it's possible for the gestational sac to fit through the tube whole. Chiavarini mentioned receiving a texted picture from her friend, another provider, of a sac pulled successfully intact, a sort of abortionist's bull's-eye. "You'll do these things," she told her audience about texting gestational sac photos. "You think you won't, but you will." The abortionist evacuates the products of conception through the cannula and attached tubing, into the aspirator, which is emptied into a bucket.

Despite what the name might imply, surgical abortion is quicker and simpler than medication abortion, and it's the more common procedure. "The truth is, doing most abortions is technically easy," Chiavarini said. "But patients bring with them their stories and their complex lives and situations, and that's the part that's hard." Whether surgical or medication, serious complications are rare. Chiavarini listed penicillin, driving, and (indeed) giving birth as statistically riskier.

> "We've been put on the periphery of medicine because we do the dirty work."

While American maternal mortality has increased alarmingly in recent years (an increase of almost 60% from 1990 to 2015), the number of abortion mortalities is so low that the Centers for Disease Control and Prevention (CDC) calculates using five-year averages. Over the last three years for which there are data (2011–2013), the CDC

reported 10 total abortion deaths, and the agency has not recorded a fatality due to an illegal abortion since 2004. It's in the interest of pro-abortion-rights protesters and antis alike to dramatize the dangers around the procedure, but the numbers are a testament to the quality of care at the clinics—most visibly, Planned Parenthood—that perform 95 percent of abortions in the United States.

One reason abortions are safer than they used to be is that the patients who seek them do so earlier. At legalization in 1973, fewer than 40 percent of abortions occurred in the first eight weeks of pregnancy; now, it's up to two-thirds, and over 90 percent are performed in the first trimester. That means that most patients who choose to terminate a pregnancy do so during their first missed menstrual cycle and before the embryo develops into a fetus.

Factual statements like these have a political quality to them, but they're also essential to understanding the procedure. As the only group eager to talk about specifics, antis have defined abortion in the public imagination. But compared to the "baby-killing" picture Americans of all ideological positions have internalized to a certain degree, the tools are incredibly small. The smallness of the cannula, for example, presents a problem for anti-abortion propagandists, who insist on depicting products of conception as having visibly human features, rather than the actual pearl-sized cell clusters they are.

But as overwhelming as the antis are—both vigilante and in government—the providers and students seemed most frustrated with a medical establishment that has marginalized them and overloaded them with work at the same time. There's pride to being part of the small corps of abortionists, both in the work they do and in the obstacles they have to overcome to do it. They're idols in the progressive feminist communities they belong to. But not everyone who wants to perform abortions also wants to be brave for a living. Today, they're not left with much of a choice.

. . .

R was at the conference from the California Bay Area—members of her chapter were identifiable by their matching "I [picture of a uterus] CHOICE" shirts—and though she wants to be a provider, the idea worries her family. "The dream is to work in an academic medical center," she said. "It would feel safer to be part of a large institution, where

you're more anonymous." Besides, R added, "They have more doors." She didn't mean that universities provide more paths for professional advancement. She meant that the buildings have fewer choke points where she could be harassed or attacked, compared to the small clinics. But compared to those two-door clinics with their lines of protesters, no one else comes close to pulling their weight when it comes to providing abortions. For students like R, there's no real middle path.

Small clinics make up less than half of abortion facilities, but they perform nearly all procedures. In the '70s, in the wake of *Roe v. Wade*, American hospitals performed about half of abortions. But just because it was legal didn't mean the medical establishment liked doing it, or was well-prepared to perform the emotional labor required.

Activists built women's health clinics to pick up the slack and to provide care informed by feminism. There's little doubt that the clinics were better able to perform abortions, and they've even kept the price stable for near 30 years—around $500 average out-of-pocket in today's dollars, a real bargain compared to what pre-*Roe* doctors charged—shielding patients from decades of medical sector hyperinflation.

> By shutting abortion out of the schools and hospitals, the medical establishment has avoided reckoning with its own fundamental deficiencies.

But there have been downsides. In a dynamic common to many gendered divisions of labor (e.g., "I'm no good at washing dishes!"), hospitals used the feminist clinics as an excuse to stop doing the work. The pay for providers decreased in real terms, and isolated from larger institutional support, these clinics have become easier targets in all senses of the word. Now they're closing at what *Bloomberg* called a "record pace"—a net loss of 141 clinics between 2011 and 2016.

Most doctors can keep their hands clean because they know people like Chiavarini will do whatever it takes. "You work so hard in school, you go into debt, you work hard some more, people want to kill you, and your colleagues see you as lesser-than," she told me. It's the last part that seems to sting sharpest. "We've been put on the periphery of

medicine because we do the dirty work. It's a thing that people don't want to talk about. We're there when those other doctors need us, but they don't want to talk about it."

It's easy to understand Chiavarini's frustration; physicians in Kansas and Oklahoma will refer patients to her for procedures but won't do them, even when they're functionally identical to the uterine evacuations routinely performed after miscarriages. Dodging Christian fundamentalists while flying around the country helping women in need is, depending on the audience, superheroic. But those are also lousy labor conditions.

By shutting abortion out of the schools and hospitals, the medical establishment has avoided reckoning with its own fundamental deficiencies, while in their distinct environment, abortion providers have evolved into a different kind of MD. A recent *Vice* headline called abortion providers "America's Best Doctors," and there's a lot of evidence available to back up the claim. Language about eliminating abortion through education and contraception access misses the mark: People continuing to terminate pregnancies is not necessarily a problem to solve. In the difficult stories I heard from providers, the actual terminations didn't rank among the hardest elements. What they struggled with was the social marginalization of their patients and their own marginalization as providers. For that—unlike an unwanted pregnancy—there is no safe and reliable surgical solution.

. . .

After the conference, students returned to their MSFC chapters at school, where they continued the same project, training themselves and each other during their off-hours. They practice manual aspiration on papayas (the most womb-shaped fruit), lobby their administrations for more education access, and collect resources. When and if students are ready, MSFC will help them find ways to train, as it has in the past. Emily Young, the abortion doctor from Charlottesville, trained in Denver on an MSFC externship grant. "Two hundred procedures in a month," she said. "You see everything."

The young doctors from the ballroom who take the same leap will soon be doing the heavy lifting of providing abortions in America. When I talked to K, the woman who proclaims her ambitions in her dating profile, the one time she looked concerned was

when she thought about the work's physical demands. She rubbed her elbow, imagining aspirator-induced repetitive stress.

Faced with eliminationist aggression from the Christian right and malignant neglect from the medical establishment, the number of facilities that average more than 400 abortions a year has been dwindling since the '80s, from a high of 705 to 535 at the last published count (from 2014). But if there's one countervailing trend, it's who's wearing the stethoscope.

When *Roe* passed, women made up fewer than 10 percent of medical graduates; now, they're almost at parity, with 85 percent of OB/GYN rotations. In a 2011 survey, millennial OB/GYNs were far more likely than older doctors to say they provide abortions. It bodes well that the 2017 MSFC conference was the biggest yet. But until they're able to displace a generation of cautious baby boomer administrators, young abortionists are stuck with the responsibilities that come with caring and the consequences for sticking out.

Near the end of the conference, I met M, a 23-year-old student and future provider in Chicago. She has led a decade-long campaign to improve the representation of women scientists on Wikipedia, and she thinks the experience has been good training for the work.

"I'm used to getting called a bitch," she said. "I feel prepared."

. . .

**The names of all medical students have been initialized as an editorial choice. It does not necessarily reflect a subject's refusal to be named.*

Abortion Health Power Politics Youth Now