

# The New Abortion Providers



Dr. Rachael Phelps (left), an alumna of the Family Planning Fellowship. Dr. Emily Godfrey (right), whose specialty is family medicine, with a patient undergoing a routine checkup.

By **Emily Bazelon**

July 14, 2010

*See how this article appeared when it was originally published on NYTimes.com.*

On a clear and mild March day in 1993, the Operation Rescue leader Randall Terry spoke at a rally in southern Florida against abortion. “We’ve found the weak link is the doctor,” he told the crowd. “We’re going to expose them. We’re going to humiliate them.” A few days later, Dr. David Gunn, an abortion provider, was shot and killed outside his clinic in Pensacola, Fla., about 500 miles away. It was the first of

eight such murders, the extreme edge of what has become an anti-abortion strategy of confrontation.

Terry understood that focusing on abortion providers was possible because they had become increasingly isolated from mainstream medicine. That was not what physicians themselves anticipated after the Supreme Court's 1973 decision in *Roe v. Wade*. An open letter signed by 100 professors of obstetrics and gynecology predicted that free-standing clinics would be unnecessary if half of the 20,000 obstetricians in the country would do abortions for their patients, and if hospitals would handle "their proportionate share." OB-GYNs at the time emphasized that abortion was a surgical procedure and fell under their purview.

But then most of the OB-GYNs left the stage. After *Roe*, the shadow of the greedy, butchering "abortionist" continued to hover, and many doctors didn't want to stand in it. As mainstream medicine backed away, feminist activists stepped in. They set up stand-alone clinics to care for women in their moments of crisis. In many ways, the clinics were a rebel-sister success story. Instead of a sterile and expensive hospital operating room, patients could go to a low-cost clinic with pastel walls and sympathetic staff members. At a Planned Parenthood I visited recently in Rochester, while women were having abortions, they could look at photos of a Caribbean beach, taped above them on the ceiling.

But the clinics also truly came to stand alone. In 1973, hospitals made up 80 percent of the country's abortion facilities. By 1981, however, clinics outnumbered hospitals, and 15 years later, 90 percent of the abortions in the U.S. were performed at clinics. The American Medical Association did not maintain standards of care for the procedure. Hospitals didn't shelter them in their wings. Being a pro-choice doctor came to mean referring your patients to a clinic rather than doing abortions in your own office.

This was never the feminist plan. "The clinics' founders didn't intend them to become virtually the only settings for abortion services in many communities," says Carole Joffe, a sociologist and author of a history

of the era, “Doctors of Conscience,” and a new book, “Dispatches From the Abortion Wars.” When the clinics became the only place in town to have an abortion, they became an easy mark for extremists. As Joffe told me, “The violence was possible because the relationship of medicine to abortion was already tenuous.” The medical profession reinforced the outsider status of the clinics by not speaking out strongly after the first attacks. As abortion moved to the margins of medical practice, it also disappeared from residency programs that produced new doctors. In 1995, the number of OB-GYN residencies offering abortion training fell to a low of 12 percent.

“Under pressure and stigma, more doctors shun abortion,” wrote David Grimes, a leading researcher and abortion provider of 38 years, in a widely cited 1992 medical journal article called “Clinicians Who Provide Abortions: The Thinning Ranks.” In a 1992 survey of OB-GYNs, 59 percent of those age 65 and older said that they performed abortions, compared with 28 percent of those age 50 and younger. The National Abortion Federation started warning about “the graying of the abortion provider.” In the decade after Roe, the number of sites providing abortion across the country almost doubled from about 1,500 to more than 2,900, according to the Guttmacher Institute. But by 2000 the number shrank back to about 1,800 — a decline of 37 percent from 1982.

There’s another side of the story, however — a deliberate and concerted counteroffensive that has gone largely unremarked. Over the last decade, abortion-rights advocates have quietly worked to reverse the marginalization encouraged by activists like Randall Terry. Abortion-rights proponents are fighting back on precisely the same turf that Terry demarcated: the place of abortion within mainstream medicine. This abortion-rights campaign, led by physicians themselves, is trying to recast doctors, changing them from a weak link of abortion to a strong one. Its leaders have built residency programs and fellowships at university hospitals, with the hope that, eventually, more and more doctors will use their training to bring abortion into their practices. The bold idea at the heart of this effort is to integrate abortion so that it’s a

seamless part of health care for women — embraced rather than shunned.

This is the future. Or rather, one possible future. There's a long way to go from here to there. Between 2000 and 2005, the last year that statistics are available, the number of abortion facilities in the U.S. dropped 2 percent — a smaller dip than those in the preceding five-year periods, but a decline nonetheless. “The '90s were about getting abortion back into residency training and medical schools,” says Jody Steinauer, an OB-GYN professor at the University of California at San Francisco, the hub of the abortion-rights countermovement in medicine. “Now it's about getting abortion into our practices.”

**THE INITIAL PUSH TO** lift the status of abortion in medicine came from the profession's most junior members. In 1992, Steinauer started medical school at U.C.S.F. In the spring of her first year, she and thousands of other students received a mailing at home called “Bottom Feeder.” It made racist jokes and included this exchange: “Q: What would you do if you found yourself in a room with Hitler, Mussolini and an abortionist, and you had a gun with only two bullets? A: Shoot the abortionist twice.”

Distressed by the mailing, Steinauer started talking to students at other schools about how abortion wasn't the topic of a single class. She took a year off and started the group Medical Students for Choice. Soon chapters throughout the country began pushing to add lectures about abortion to the medical-school curriculum. “Not everyone has to do abortion, but everyone has to think about it,” Steinauer says today of M.S.F.C.'s philosophy. The point is to recruit not only future abortion providers but also the supporters they'll need inside medicine later in their professional lives. M.S.F.C. now has 10,000 members. “You know, all these students going into dermatology or radiology — if you're an OB who wants to provide and your hospital won't let you, they're the ones you want as your allies on the hospital board,” Steinauer says.

The next important moment came in 1995. With new studies showing how low the training rates for



residents had fallen, the National Abortion Federation, with M.S.F.C. as an ally, began pushing for change. The Accreditation Council for Graduate Medical Education — which represents the medical establishment — decided, for the first time, to make abortion training a requirement for all OB-GYN residency programs seeking its accreditation. The anti-abortion movement tried to smother the new mandate. The following year, Congress passed the Coats Amendment, which declared that any residency program that failed to obey the Accreditation Council's mandate could still be deemed accredited by the federal government. But the council had spoken, and medical schools and teaching hospitals listened. Today, about half of the more than 200 OB-GYN residency programs integrate abortion into their residents' regular rotations. Another 40 percent of them offer only elective training.

To establish a secure foothold in academic medicine, abortion-rights supporters knew that along with residency programs they needed the kind of advanced training that attracts the best doctors and those who want to join medical-school faculties. A physician at the U.C.S.F. medical school set up the Family Planning Fellowship, a two-year stint following residency that pays doctors to sharpen their skills in abortion and contraception, to venture into research and to do international work. In recent years, the fellowship has expanded to 21 universities, including the usual liberal-turf suspects — Harvard, Columbia, Johns Hopkins, Stanford, U.C.L.A. — but also schools in more conservative states, like the University of Utah, the University of Colorado and Emory University in Georgia.

When Salt Lake City and Atlanta are home to programs that train doctors to be expert in abortion and contraception, the profession sends a signal that family-planning practices are an accepted, not just tolerated, part of what doctors do. That helps draw young physicians. The first generation of providers after Roe took on abortion as a crusade, driven by the urgent memory of seeing women become sick or die because they tried to induce an abortion on their own, in the days before legalization. Out of necessity, the doctors pushed ahead with little training or support. “We did it by the seat of our pants,” says Philip Ferro,

an 82-year-old OB-GYN at the S.U.N.Y Upstate Medical University in Syracuse. “There was no formal source of knowledge.”

As Ferro wryly puts it, “That would not stand today.” Abortion and contraception have become the subjects of rigorous, evidence-based research. The younger doctors who are coming through the residency training programs and the Family Planning Fellowship “have invigorated this field beyond my greatest expectations,” Grimes, the researcher and abortion provider, says. “We are cranking out highly qualified, dedicated physicians who are doing world-class research. There is a whole cadre of people. I helped train some of them, and I’m very proud of that. In the 1980s, I wasn’t sure who would fill in behind me when I retired. I’m much more optimistic now.”

Many of the protégées Grimes is talking about are women. In the first generation after Roe, abortion providers were mostly men because doctors were mostly men. Since then, women have streamed into the ranks of OB-GYN and family medicine. They are now the main force behind providing abortion.

**THE PROVIDERS THAT** make up the new vanguard don’t define themselves as “abortion doctors.” They often try to make the procedure part of their broader medical practice — by spending much of their week seeing patients for general gynecology or primary-care visits, and by being on call on the labor and delivery floor. If the young doctors succeed at making abortion mainstream and respected within medicine, abortion could move from clinics to doctor’s offices and hospitals. And if that happened, would the politics surrounding it finally change? Would protesters stand outside a hospital or a primary-care clinic or a group practice that treats all kinds of patients?

By taking jobs on university faculties, the young doctors avoid walking to work through a scrum of screaming demonstrators. “Some people like to live on the edge — I don’t,” said Emily Godfrey, a 40-year-

old doctor who practices at a primary-care clinic at the University of Illinois at Chicago, where she also does abortions. “I’m a Catholic girl from the suburbs. I’m a yoga student. I like calm and serenity.”

Godfrey is tall and graceful, with auburn hair and freckles. She decided as a child she wanted to be a doctor. In her favorite course as an undergraduate at the University of Wisconsin, on the history of women in medicine, she read rejection letters that Harvard Medical School once wrote to women applicants who were turned down because they would someday marry. Godfrey started at the Medical College of Wisconsin in 1993, the same year that Jody Steinauer founded Medical Students for Choice. Godfrey put most of her extracurricular energy into working with domestic-violence victims. But as a third-year student, she went to an M.S.F.C. meeting at which an internist who did abortions suggested a book called “The Story of Jane.” It was about a few women in Chicago, in the years before Roe, who were furtively trying to help other women in their desperate search for illegal but safe abortions. Godfrey still has her copy. “Women had to meet strange men who were supposedly doctors in a hotel room or in somebody’s kitchen,” she recalled. “To ask a woman to show up secretly like that and hope some guy won’t take advantage of you — to me, it was horrible. I started thinking that I wanted to be the one to make sure that women in that situation could be dignified.”

After graduation, Godfrey started her family-medicine residency in a hospital on Chicago’s West Side. It bordered gang territory. On her obstetrics rotation, Godfrey delivered baby after baby to poor women who seemed overwhelmed. Some were drug addicts. “Bringing so many unwanted children into the world, or children who wouldn’t be readily provided for because their mothers were on drugs or who were taken away at birth — well, that just solidified my feeling that I wanted to provide abortions,” she told me. Godfrey read up on contraception and learned that IUDs can be safely inserted right after delivery. But Medicaid refused to pay for a delivery and this second procedure in one day. “Many of my patients were getting pregnant again, without intending to, and it was extremely frustrating,” she says.

When a friend gave her a flier about the Family Planning Fellowship, Godfrey saw it as a way to learn a skill she wanted to have, try her hand at research and travel abroad. Most Family Planning fellows are OB-GYNs; Godfrey was one of the first family-medicine doctors in the program. Family physicians deliver babies, set broken arms, remove precancerous moles. Because they're more likely than specialists to work in rural areas, they are for abortion-rights advocates the best hope of bringing more providers to the parts of the country where hundreds of miles roll by without one.

Godfrey spent the two years of her Family Planning Fellowship at the University of Rochester, where she did enough abortions to "train to competency," the term for doing a sufficient number of supervised abortions to be fully qualified to do the procedure alone. The rate of complication for first-trimester abortions that require hospitalization is so low (fewer than 1 in 100) that doctors often have to do the procedure scores of times to learn what to do when something goes wrong.

Godfrey also went to Nicaragua and Mexico to learn about those countries' reproductive-health services and to the World Health Organization in Geneva to do research. Now she's publishing W.H.O. data on using the IUD, inserted after unprotected sex, as emergency contraception. (It works surprisingly well, though it's not yet entirely clear how.) The fellowship's international component means that young doctors see the kind of suffering that their predecessors saw in the U.S. before Roe. "In Kenya, a woman came with a stick hanging out of her," says one doctor whose fellowship took her to Africa so she could train nurses to treat complications from illegal abortions. "You bring in this inexpensive, reusable equipment to places without electricity or running water, and you teach nurses to use it, and you save women's lives."

The first fellowship-trained doctors mostly took jobs in cities that were already flush with abortion providers — San Francisco, New York, Boston. Now positions in those places are filled, and the fellowship alums, who number more than 20 per year, are spreading out. In Chicago and even Rochester, there isn't

one lone fellowship-trained physician. There are clusters. They go out for drinks together. Nationally, the fellows have annual meetings and an e-mail list on which they ask one another's advice. "More than anything, what's hard about this work is that there aren't a lot of people you can talk to about it," says Sunni, a colleague of Godfrey's and a 40-year-old OB-GYN whose parents immigrated to the United States from South Asia. "That's probably the most important thing we do for each other."

Godfrey and Sunni (who asked to be identified by a nickname to protect her privacy) have known each other since they met eight years ago when they were both fellows. The three of us had lunch together in April. Godfrey talked about the first job she took after she finished her fellowship and went back to Chicago. While she looked for a position on a medical-school faculty, she worked one day a week at an abortion clinic 90 miles away in the northern Illinois town of Rockford. The doctors there were the only providers within miles.

The owner of the Rockford clinic was Richard Ragsdale, a Vietnam veteran who'd opened his doors the day after *Roe v. Wade* was decided. The first time Godfrey came to work, Ragsdale wasn't there. A nurse showed Godfrey old-fashioned metal instruments that she'd never seen before. Godfrey made do as best she could. Before she could come back to meet Ragsdale the following week, he died. "They called me and asked, 'Are you our doctor now?'" she remembered over lunch.

For the next two years, Godfrey drove to Rockford one day a week. Once she prescribed birth control for her first patient, everyone in town knew her as the new abortion doctor. Protesters surrounded her when she walked into the clinic. One day, a clinic resident left his lunch in the car and said he'd rather be hungry than go back to get it.

Godfrey tried to act tougher than she felt, but the work wore on her. Meanwhile, an OB-GYN in his 60s

started working at the clinic, and his unruffled calm seemed like a rebuke. “The older docs — those guys knew how to stand on their own two feet,” she said. “He was immune to everything. But emotionally, for me, it was too hard.”

And then one snowy day in 2007, Godfrey had a patient with a serious complication who needed to go to the hospital. She called the OB-GYN who was supposed to be on call. He was out of town. She called Sunni, who told her to get the patient to the local hospital. But Godfrey had no admitting privileges there, and the doctor on call seemed unwilling to admit the patient. “She said, ‘How dare you come here,’ ” Godfrey remembered. She looked down at her salad, her face flushed.

“You were really out there all alone,” Sunni said.

Godfrey nodded. “Yeah, I remember you said that,” Godfrey said. “And I was like, God, you’re right.” Godfrey called George Tiller, the veteran abortion provider who was later killed at his Kansas church in 2009, to ask his advice. He told her to call an ambulance and send the patient to the hospital.

Godfrey did, and the woman was admitted; she got the care she needed, and in the end she was fine. But Godfrey was shaken. So was Sunni, who told us about a dream she had after that tense day about Godfrey going back to Rockford. “The clinic got destroyed somehow. I saw you in the rubble, still working. And I said: ‘This is ridiculous! Come home!’ ”

A year later, Godfrey stopped going to Rockford. By then she had started at the University of Illinois as an assistant professor of family medicine. This is the job that allows her to be an abortion provider with “a normal life,” as she puts it. “You know what, I’m a single woman who still wants to get married,” she says. “I will not be flying and driving around rural Midwest America. I’m not willing to be out on that frontier.”

**IN 1999, UTA LANDY**, a former director of the National Abortion Federation, and Philip Darney, her husband and an OB-GYN professor at U.C.S.F., created the Kenneth J. Ryan Residency Training Program. The program gives medical schools two or three years of seed money for abortion training for OB-GYN residents. Through it, 58 campuses in the U.S. and Canada have received financing. Landy also directs the Family Planning Fellowship, with Jody Steinauer as the associate director.

When I e-mailed Landy in January to set up an interview, she wrote back that her policy is not to speak to the press. Steinauer explained that the organization fears that the publicity might scare away a university considering a Ryan or fellowship grant. Or it might spook the donor, other doctors told me.

The money for the Ryan and the Family Planning Fellowship comes from one foundation and from one family. The donor has chosen to remain anonymous, which helps to explain why there's been so little publicity about the pro-choice strategy of bringing abortion into academic medicine. It has been covered by a veil of semisecrecy.

At the same time, as the Ryan and the fellowship have expanded to dozens of institutions, many people have come to know about the source of funding. In the course of my reporting, two doctors who had not done the fellowship themselves, but who work in universities, volunteered to me that the money for the programs comes from the Buffett Foundation. They meant the Susan Thompson Buffett Foundation.

Susan Thompson Buffett was married to Warren Buffett and served as president of the foundation that bears her name. She died in 2004. Two years later, Warren Buffett gave the foundation about \$3 billion. He said that he expected the gift to increase the foundation's annual expenditures by \$150 million. And in fact, total giving by the foundation, where two of the Buffetts' children sit on the board, increased from \$202 million in 2007 to \$347 million in 2008, according to tax returns.

The tax records also show that most of the foundation's spending goes to abortion and contraception advocacy and research. According to Access Philanthropy, a research institute that focuses on the giving preferences of foundations and corporate donors, family planning is one of the Susan Thompson Buffett Foundation's main purposes. The foundation's nonprofit 990 tax form shows that in 2008, Planned Parenthood and its affiliates in the U.S. received about \$45 million; the international arm of the organization got about \$8 million. There is no line item for the Ryan program or the Family Planning Fellowship. But the foundation paid out around \$50 million to universities with one or both of the programs.

Warren Buffett has never spoken publicly about his views on abortion. But in the 1990s, according to The Wall Street Journal, the Buffett Foundation helped finance the research and development of the pills that induce abortion. The foundation also helped finance a lawsuit to overturn the ban on so-called partial-birth abortion in Nebraska, Buffett's home state and the headquarters of his company, Berkshire Hathaway. (Susan Thompson Buffett moved from Omaha to San Francisco in 1977 but remained close to her husband. She took credit for introducing him to the woman he has lived with since 1978; the three sent out Christmas cards together.) In Thompson Buffett's only television interview, which was broadcast after her death, she told Charlie Rose: "Warren feels that women all over the world get shortchanged. That's why he's so pro-choice."





Dr. Ray, an OB-GYN in upstate New York.

Jocelyn Lee for The New York Times

Buffett hasn't been a target of heated protest — his plainspoken Midwestern persona and his enormous wealth may make him the wrong enemy for anti-abortion advocates. But in 2001, a right-wing activist named Thomas Strobhar showed up at Berkshire Hathaway's annual meeting with a shareholder resolution objecting to donations to Planned Parenthood, via a program that allowed shareholders to make gifts through the company to charitable organizations of their choice. Buffett ended the giving program two years later.

In 2006, Buffett announced his \$3 billion gift to the foundation in a letter that's written in a kind of code. He and his late wife had established the foundation, he wrote, "to focus intensely on important societal problems that had very limited funding constituencies."

"You mean you didn't know Warren Buffett's foundation has been funding abortion-rights organizations?" NPR reported at the time. "Well, that's just the way the Buffetts wanted it." The Web sites for the Family

Planning Fellowship and the Ryan program are also discreet. A private log-in is required to read more than basic information.

The foundation could have been straightforward about its work from the start. Instead, according to some doctors involved with the programs, a low profile eased the way for universities to sign on for the fellowship and the Ryan. Landy and others administrating the grant programs continue to express concerns about the implications of publicity (including this article). Buffett and Allen Greenberg, the director of the foundation, and Buffett's former son-in-law, declined to speak to me on the record.

And yet for all the anxiety about being in the spotlight, the surprising truth is that however embattled abortion remains in America at large, at the top of academic medicine, the structure built to support it looks secure. David Grimes, the researcher, is on the committee that chooses the Family Planning fellow at his university, and this year, he said, there were so many well-qualified candidates that they turned some down. Grimes surveys the terrain — the annual meetings with presentations of top-flight research, the schools where Medical Students for Choice and residency training and the Family Planning Fellowship are flourishing — and says with satisfaction: “A few things have happened to turn it all around. Thanks to the donor, I think it’s all here to stay.”

Medical schools that host the Ryan and the fellowship have, however, experienced the occasional protest. Last fall, an anti-abortion newsletter reported that the Family Planning Fellowship had come to Washington University in St. Louis. (In fact, the fellowship began there in 2007.) The author, Joe Ortwerth, posted the names and mailing addresses of key “decision makers,” including the chancellor and chairman of the board of Washington University. “You may wish to contact them to urge that they put an end to this shameful and insidious relationship with Planned Parenthood,” Ortwerth wrote. “Please pray for them as you send such messages that they will receive your communication with an open heart.” The newsletter

later reported that the Family Planning Fellowship had posted on its Web site that Wash. U. was running the fellowship in collaboration with St. Louis University, a Catholic school.

In The St. Louis Post-Dispatch, St. Louis University denied any involvement. Washington University apologized for the mention of St. Louis University on the fellowship Web site. In a letter to the editor published in The Post-Dispatch, Ortwerth wrote, “It is shameful for Washington University to attempt to dignify the dirty business of abortion by awarding academic fellowships to future abortionists.”

The flap ended there, and Washington stuck with the fellowship. Still, such controversy isn’t welcome at most universities. The doctors who run the Ryan and fellowship programs aren’t trying to hide, they say. But they don’t want to be singled out. When I asked to visit medical schools where doctors like Godfrey are performing abortions, some of them asked not to be the only university I mentioned. “We want to fight the battle, but not all of us are martyrs,” said Leo B. Twiggs, chair of the OB-GYN department at the University of Miami in Florida, where two fellowship-trained doctors perform first- and second-trimester abortions as part of their gynecology practice. “Everyone was nervous when you asked to come. We basically said that if we really believe in what we’re doing, we should be able to talk about it. But we don’t want to be especially known for pregnancy termination.”

Many of the two dozen young doctors I talked to for this article were similarly conflicted. They wanted to talk about their work. They see it as part of making abortion mainstream. But the murder of Dr. George Tiller last year scared them. One 33-year-old family-medicine doctor I met in Rochester drives 90 miles each week to perform abortions at a clinic in Syracuse. She is pregnant with her third child, and she asked me not to use her name after her father insisted that she’d be putting herself and her kids at risk. Still, at her Episcopal church, where she feels safe, she is open about what she does. “When people are surprised, I say, ‘Yes, a Christian can also be an abortion provider,’ ” she told me.

**EMILY GODFREY**, too, has reckoned with the sensitivity of her line of work. She was brought up in a casually Catholic home in which abortion wasn't discussed. Her mother strongly supports her. Privately, her father does, too. But while he thanked her for telling him when she won a local award for her work, he didn't come to the ceremony.

Godfrey has treaded carefully at the University of Illinois. When she joined the faculty, she got a grant to train residents to do abortions. (The money came from a sister program to the Ryan for family physicians, called the Center for Reproductive Health Education in Family Medicine.) But Godfrey started slowly: during her first year, in 2006, she handled only primary-care visits at the university-run clinic where she sees patients two days a week. She stressed contraception, increasing the number of patients getting IUDs — one of the most effective forms of birth control — from fewer than 15 to more than 90 a year.

As Godfrey came to know the nurses and front-desk staff at her primary-care clinic, she learned that some of them flatly opposed abortion. They've come around, she says, out of mutual professionalism. She doesn't object when nurses don't want to assist her, and she tries to meet them halfway by doing abortions only up to nine weeks of pregnancy. The early threshold means that no one on staff has to contend with recognizable fetal parts. "It was a way of being respectful, because I know that not everyone agrees with me and what I do," she says. After I watched Godfrey coach one of the residents she trains through a surgical abortion for a 22-year-old college student who was six weeks pregnant, we went to the clinic's utility room. The resident floated the pregnancy tissue in a glass dish of water, for a routine check. Amid the uterine tissue was a gestational sac about the size of a dime surrounded by millimeters-long white villi, the fronds that later help form the placenta.

In the clinic's waiting room, it's impossible to tell who has come because of a stuffy nose or chest pain, or for birth control. In this setting, Godfrey can take care of a pregnant woman whether she chooses to keep the

baby, put it up for adoption or end the pregnancy. To her, this is the core of an integrated practice. “I have nothing to gain or lose whatever my patient decides,” she told me. “I’m just being her advocate and her family physician.”

A first-trimester abortion is low-risk, relatively simple and fast — a skilled doctor can do it in less than five minutes. It’s the traditional province of OB-GYNs, but it also fits easily within the scope of care of family-medicine doctors, who do other minor procedures, like endometrial biopsies, which screen for uterine cancer. So far, only a small number of the family-medicine residencies offer abortion training. But those programs are attracting applicants — they have higher match rates, which means greater success in recruiting the residents they want.

Technological advances have made it easier to shift abortion to the earlier stages of pregnancy. Tests have become sensitive enough to detect pregnancies two weeks after conception. The M.V.A., or manual vacuum aspirator, is gradually replacing the electric pump as the equipment of choice for first-trimester procedures. It’s about 10 inches long, costs only \$30 and looks like the kind of appliance you might find in a kitchen drawer. Lawrence Leeman, a family physician at the University of New Mexico, describes how he convinced skeptical nurses that their primary-care clinic could handle abortion by coming to a meeting with his M.V.A. supplies in his coat pocket. Even smaller, of course, are the pills for a medical abortion.

Most facilities that offer surgical abortions now offer medical ones too. And in fact, Godfrey also does medical abortions up to nine weeks: she gives patients the pills misoprostol and mifepristone (formerly known as RU-486) and sends them home for an induced miscarriage, with a follow-up visit to make sure there are no complications. When the Food and Drug Administration approved medical abortion 10 years ago, abortion-rights advocates hoped that the method would move into the offices of doctors who don’t do surgical abortions. That shift hasn’t much happened. But medical abortion has helped to increase the

number of very early abortions. It has long been an abortion-rights selling point that almost 90 percent of the abortions in the U.S. are performed before 12 weeks; in addition, four years ago, the proportion of procedures performed before 9 weeks reached 62 percent. The statistic points to a paradox: Anti-abortion advocates succeeded in focusing the country's attention on graphic descriptions and bans of late-term abortion even as more and more women were ending their pregnancies earlier and earlier.

**DOCTORS WHO PERFORM** abortions are startled by some poll numbers showing that for the first time, more Americans call themselves pro-life than pro-choice — a shift that includes young people. I saw hints of that discomfort. Medical residents with a moral or religious objection can always choose not to participate in abortion training, and in Godfrey's program this year, four out of seven did not take part. When I visited the Planned Parenthood in Rochester, a 29-year-old pediatric resident came to watch the nurses counsel patients about their options but chose not to see an actual abortion. "I don't know how I personally feel morally, and I'm never going to do one," she said. "So if it could bother me if I saw one, then what's the point?"

Godfrey trains her residents to do abortions up to 13 weeks by taking them one afternoon a week to a hospital where her colleague Sunni runs an abortion service as part of her OB-GYN practice. When the residents finish their training, Godfrey asks them how they feel about doing the procedure at 7 or 10 or 13 weeks. "Some will say, 'I'm perfectly O.K. going up to 10 weeks, but after that I can see more of the fetus moving on an ultrasound, and I'm just not comfortable with that.' " She has set her own threshold at 14 weeks. "I'm not an OB-GYN, and I'm not a surgeon, and that's as far as I can safely go," she said. "But to be honest with you, I haven't seen a lot of terminations past 19 weeks. There's a part of me that's almost grateful that it's not even an option for me."

These graduated choices are a delicate subject within the field. The abortion providers I talked to are

intensely grateful to the doctors who are willing to handle difficult late-second-trimester cases. But they also see the moral complexities up close. Two years ago, a young professor at the University of Michigan named Lisa Harris wrote an academic article about performing an 18-week abortion while she was 18 weeks pregnant. Harris described grasping the fetus's leg with her forceps, feeling a kick in her own uterus and starting to cry. "It was an overwhelming feeling — a brutally visceral response — heartfelt and unmediated by my training or my feminist pro-choice politics," she wrote. "It was one of the more raw moments in my life."

Other abortion providers have sorted through related issues. When Sunni was pregnant, some of her patients asked how she could perform an abortion while she was carrying a child. "I said: 'There's a time for everything. This is my time. Yours may come later.' " When Harris's article was the subject of a workshop at one of the Family Planning Fellowship's annual meetings, Sunni remembers the difficult emotions that came to the surface, and also the concern about how the article had been depicted in the anti-abortion press, its most graphic passages quoted as evidence of hypocrisy and folly. "We want to bring this discussion more to the forefront," Sunni says. "But it's a bit dangerous. Because people can misconstrue what we mean."

**SINCE BEFORE THE** days of Roe v. Wade, a small number of doctors have quietly provided abortions in their offices (often only for patients with health insurance or who pay out of pocket). Their numbers have dwindled: in 2005, the Guttmacher Institute counted 367 abortion providers in doctors' offices nationwide, down from more than 700 in 1982. Doctors' offices now account for only 2 percent of the total number of procedures; hospitals account for barely 5 percent.

This highlights the challenge of making abortion truly mainstream — of moving beyond residency training and outside the haven of medical-school faculties, so that more doctors offer abortions when they join a

regular OB-GYN or primary-care practice. As yet, all the success in training new doctors hasn't translated into an increase in access. Abortion remains the most common surgical procedure for American women; one-third of them will have one by the age of 45. The number performed annually in the U.S. has largely held steady: 1.3 million in 1977 and 1.2 million three decades later. In metropolitan areas, women who want to go to their own doctor for an abortion can ask whether a practice offers abortion when they choose an OB-GYN or family physician. But in 87 percent of the counties in the U.S., where a third of women live, there is no known abortion provider.

OB-GYNs who learn to do abortions during residency are more likely to offer the procedure when they go off to practice, according to a 2008 study that Jody Steinauer helped write. And yet a study published this month, which she helped conduct (along with Darney, Landy and Lori Freedman of U.C.S.F.) offers an explanation for why the numbers of providers have continued to fall: the shift to group medical practice. The authors interviewed 30 OB-GYNs with abortion training. Eighteen said they wanted to provide abortions after residency. But 15 of them weren't actually doing so. One doctor from a midsize city in the Midwest described her job interview at a group practice: "The one partner who's very senior in the group and very pro-life, basically his only job is to sit with you and just tell you . . . 'If you join this group, you will not be performing abortion procedures. And if that's a problem for you, then you will work elsewhere. O.K.?' " Another doctor from the suburbs of a big Western city said that she refers her patients to Planned Parenthood. "Actually, in my first couple of months in practice, the people that are in my office here told me, 'Don't even bother,' " she said of wanting to perform abortions. For family-practice doctors, medical-malpractice insurance is an additional barrier. According to one 2008 study, coverage for abortion often costs them an extra \$10,000 to \$15,000 a year.

Even doctors who practice solo and have all the insurance they need can find themselves in delicate negotiations over abortion. Ray, who is in his 30s, is an OB-GYN in upstate New York who learned to do



abortions during his residency. As a teenager, Ray (who asked that I use only his middle name) saw his brother's fear when he got his girlfriend pregnant. Race also mattered in Ray's decision to become a provider; he is African-American. "We utilize the service a lot, but publicly we don't really support it," he said of the local black community.

We talked in his office, which was simple and old-school: issues of Redbook and Good Housekeeping were in the racks in the waiting room. The office is in a building that has a volatile history. In the early 1990s, protesters from Operation Rescue came frequently to the building to protest the presence of an outspoken OB-GYN who provided abortions. When Ray took over a different practice in the building, he decided to get hospital privileges so he could schedule surgical abortions in the O.R. He also wanted to give patients the pills for a medical abortion in his office.

But first Ray sat down to talk with Ann, the nurse who'd worked for more than 25 years in the practice. Now in her early 60s, Ann (her middle name) is a Catholic grandmother who celebrates Mass every Sunday. She was adamantly opposed to abortion. She was also a fixture in the office; she knew all the patients. "Here I am, a young doctor, taking over an old practice with a lot of women patients who have kids my age," said Ray, who has children of his own. "I needed someone to back me up when I got here. She did that for me. I didn't want to let her go."

And so Ray and Ann worked out a compromise: He would handle the abortion patients entirely on his own. When a woman calls to ask for a termination, Ann and the office manager take down the patient's name and number and then have nothing more to do with the case. Ray does the scheduling, counseling and billing along with the care. He and Ann agreed that when he did medical abortions, he would give the patients the pills in the office, because the women actually ended their pregnancies at home. "We have a mutual understanding: no surgical abortions here, and we treat medical abortion as a gray area," Ray says.

When I talked to Ann — Ray offered her his office chair while he saw a patient — she said that when Ray took over the practice, she and the office manager, another woman in her 60s, weren't sure if they would stay. "We didn't want a young doctor with attitude," Ann said. "We're too old for that. But we gave him a chance. And he has exceeded our expectations wildly. I thank God every day, because he's so good with the patients. I'm just blessed. Other than the little termination thing — " she made a small box with her fingers and then moved her hands to her left, as if to set the box aside.

Ann reassures herself that Ray is never casual about abortion. "He makes the women think about it longer, to make sure they know this is something you have to live with forever." She also told me something Ray hadn't mentioned. "If a patient calls and she's not sure, I ask, 'Have you looked into other things?' I say, 'Come in and let's talk.' I tell her that if adoption might be a difficult situation, there is other help out there. I may refer her to a crisis pregnancy center" — an anti-abortion organization that counsels pregnant women to keep their babies. In 2006, Congressional investigators found that most federally financed crisis pregnancy centers they contacted gave out wrong information like tying abortion to breast cancer or infertility or mental illness. Yet as part of the compromise between doctor and nurse, that is where Ann says she refers some women who call Ray's office.

At the same time, Ray is on guard for the warning signs that a pro-life activist is posing as a patient: the woman who calls at an odd time of day close to the anniversary of Roe v. Wade, or who says that her name is "Rebekah, spelled the Biblical way," or who seems too motivated. "When Operation Rescue was in the building, it was borderline terrifying," Ann told me. "Seriously. You didn't know — would there be a pipe bomb? I don't want the doctor to get in trouble. I don't want to go back to that."

**EVEN IF DOCTORS** like Ray were to suddenly multiply, stand-alone abortion clinics would still be the mainstay of abortion provision in the U.S. for the foreseeable future. For one thing, the clinics are efficient

and relatively low cost. For another, “training to competency” demands a high volume of patients for residents to treat. Most hospitals and doctor’s offices do dozens or at the most hundreds of abortions a year. High-volume clinics do thousands.

Given the importance of the clinics, many abortion-rights physicians would like to pull them into the medical-school orbit. At the moment, universities tend to keep clinics at arm’s length. If they send residents for training, it’s sometimes for an off-site rotation that the medical-school faculty does not supervise. But the relationship can be closer.

I went to visit Rachael Phelps, who is the associate director of Planned Parenthood for the Rochester/Syracuse region and a fellowship-trained doctor who works in a stand-alone clinic. She is a pediatrician with a special interest in adolescent reproductive health. Phelps, who is 40, has flower stickers plastered on the E-ZPass on her windshield. She is steely, though: she does the kind of job that many other doctors shy away from — she walks or drives by protesters every day. When we ate lunch at a restaurant down the street from her office, they waited for her outside. “Dr. Phelps, you kill babies and hurt women,” one shouted as she walked past. “What’s the matter with you?”

Before Phelps became a doctor, she was a patient. As a teenager, she developed endometriosis, a painful, scarring condition with no known cause in which the cells that line the uterus — and sometimes other parts of the body — grow out of control. Phelps’s case went undiagnosed for years. During her first year of medical school, at Johns Hopkins, she had major abdominal surgery to reconstruct her ovaries, which had been damaged by the spreading uterine cells. But nine months later, the endometriosis had spread again. The only treatment option left was a hysterectomy and removal of her ovaries. She was 23. Her doctors balked. “The doctors didn’t have the guts to say it,” she says. “I had to beg for the thing I didn’t want. I promised myself that if I ever got well enough to finish medical school, I would never do that to a patient.”

At Planned Parenthood, Phelps can throw herself into that promise. “Women who come to us for abortions are sometimes scared and upset and heartbroken,” she says. They often have young children at home. “If I have the capability to help them, then I should do it. Because most people will not. So if I’m willing, how can I stand by?”

While doctors like Godfrey bring abortion into academia, Phelps is bringing academia to abortion. She has been working with two members of the University of Rochester OB-GYN faculty to start a joint program for residents. The idea is for all three physicians to work alongside one another at Planned Parenthood while they train younger doctors — another kind of mainstreaming.

**IF YOU THINK** of the effort to increase training and access to abortion as a marathon, has it reached the halfway point? I asked Rachael Phelps a version of this question when she dropped me off at the Rochester airport. She looked out the window, at all the people whom she wished could feel the urgency she does, and pointed out that change in medicine comes slowly. “It takes 10 years from the beginning of medical school to get someone fully trained,” she said. “Remember, we’ve had a lot of catching up to do.” She brightened, mentioning a family-planning faculty position at Syracuse University that had just been filled after a three-year search. “It is changing,” she said. “When I was in medical school, there was no curriculum, no national conferences with exposure to speakers with amazing training. Now I’m here, and so are my colleagues at the university, and we have this new person coming to Syracuse. It’s so much easier when you’re not on your own.”

Emily Godfrey, too, is looking ahead. She’s about to apply for tenure — the only clinical faculty member in her department to do so. “You know, we’re now getting to the point where the people in our cohort are starting to take on these positions at the senior level,” she said. “It kind of makes you laugh, to think of yourself like that. But we see the new residents and fellows coming in, and we have a whole structure set up

for them.”

We were talking in the office of one of Godfrey’s OB-GYN colleagues. The door opened, and a 33-year-old family-planning fellow walked in. She and Godfrey conferred about a paper they’re writing together. Then the younger doctor hurried off. She had patients to call.