What It's Like to Take On the Most Vilified Job in America

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Sam Avery knew she could find what she needed at the All Families clinic, because she'd seen the protesters outside when driving through town. Their "Pray to End Abortion" signs billboarded an otherwise discreet service in Kalispell, Montana, population 22,000. It's the kind of town where churches outnumber supermarkets and gay pride parades draw counter-protests. The clinic's owner had a nickname: "Susan Cahill the baby killer," says Avery. "She's got that label for the rest of her life."

Avery got pregnant after quitting the hormonal birth control that was making her sick. She decided to get an aspiration abortion, one of the most common surgeries in the U.S., which takes between three and 10 minutes to complete. Avery's drive to All Families took four hours from her then-home on the Blackfeet Indian Reservation through Glacier National Park and across the Continental Divide. When she finally met Cahill, she gleaned a different impression from others in town: "She's a rare mix of badass and surly and also caring and understanding. She has the right proportions to be really good at what she did."

Cahill, a 66-year-old physician assistant with an olive complexion and hazel eyes, had been providing abortions and other primary health care services for four decades in Western Montana. She'd outlasted an arson attack in 1994 and a state law in 1995 that sought to ban Physician's Assistants from performing abortions. (Advanced Practice Clinicians, like PAs, can legally perform aspiration abortions—those done in clinics—in five states. They can prescribe the abortion pill in 12.) The only PA in Montana performing abortions at the time, Cahill spent four years challenging the law in court, and won. "Your conviction has to be stronger than the societal hassles you endure to have your conviction," Cahill told me.

Avery and Cahill became friends, and in the summers of 2012 and 2013, Avery shadowed Cahill. Avery, then 25 and a recent graduate of the University of Montana who had majored in biochemistry, was considering applying to medical or physician's assistant school. And her own abortion experience had made her realize "how important it was to have someone knowledgeable and understanding" as a provider. Cahill hoped Avery might one day consider taking over All Families. She was in her early sixties, after all, and finding a successor had proved difficult so far.

Nationwide, and especially in rural areas, there is a shortage of clinicians willing and able to perform abortions. In 2005, 87% of US counties had no abortion provider, according to the Guttmacher Institute, up from 77% in 1978. Meanwhile, many clinicians who provide are nearing retirement. In a survey of National Abortion Federation members published in 2008, 64% of providers who did first-trimester surgical abortions were over the age of 50.

Young people interested in entering the field face an Everest of hurdles: Only about half of ob/gyn residency programs offer routine training in abortion—though 97% of ob/gyns will see a patient seeking one during his or her career. In the past five years, Targeted Legislation of Abortion Providers, or TRAP laws, have helped close 29% of U.S. abortion clinics, according to an analysis by Bloomberg. Abortion providers are routinely harassed and attacked: According to the National Abortion Federation, abortion providers in 2015 received 94 threats of death or physical harm. Four clinics were arsoned, 67 were vandalized, and one, in Colorado, was attacked by a gunman, who killed three and wounded nine others. (Though these instances of violence have declined overall since the 1990s, 2015 saw a spike.)

All of it begs the question: How crazy do you have to be to become an abortion provider today?
In rural, conservative places like Kalispell, intense stigma makes living a normal life impossible. For former Montana ob/gyn Susan Wicklund, efforts to ensure safe passage to work included wigs, a bulletproof vest, a pistol, and a late-night dash through the forest when protesters blockaded the road to her home with cement-filled barrels.

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Wicklund wrestled with this question in her 2008 memoir, which chronicles acts of harassment and violence from as early as 1989. (“Why was I doing this?” she asks in one passage. “Why shouldn’t I enjoy a more normal existence?” in another.) In 2016, the difficulties facing would-be abortion providers are not new—they’re infamous. The kind of person who can look past them—or perhaps, is drawn towards them—has a particular disposition. Sam Avery calls it “Susan Cahill courage.” The sister of one ob/gyn resident considering a career providing abortions in the rural South said she “fixates on something systemically wrong.” Wicklund wrote that it’s tenacity spiked with spite*:* “I absolutely couldn’t let the antis have the victory of keeping me from the clinic for even one day.”

Whatever it was, Sam Avery doubted she had it. Avery, 29, has dark red hair and a runner’s build. She describes herself as sensitive, an advantage to working with patients but a liability when it comes to standing up to critics in Kalispell. “The negative letters and people calling me a witch, threatening me, kinda indirectly, saying bad things about me, even if I knew they were wrong…They wouldn’t bounce off me that easily,” she says. She and Cahill negotiated

hostility in Kalispell differently. “Susan would say, ‘You shouldn’t be afraid to tell people what you’re doing if you really believe in it.’ And I’m like, ‘I’m not like you.’ I don’t like to offend people.” Eventually, during her time shadowing Cahill, Avery decided she wasn’t up for the job. “I couldn’t put my family in that position, or my future family.” Her conviction that abortion should be legal and accessible never wavered.

In March 2014, All Families was vandalized. A receptionist arrived one morning to find windows and doors were smashed. Medical supplies were strewn across the floor, and faces in family photos had been systematically gouged with a sharp object. Patient files were drenched in iodine and dumped from cabinets, or missing altogether. The clinic location was brand new: All Families had been forced to move recently, after its previous landlord sold its building to the board member of a local anti-abortion group. Police arrested the board member’s son, Zachary Klundt, in connection with the break-in. He was eventually found guilty of felony burglary, theft, and criminal mischief and sentenced to 20 years in prison with 15 of those years suspended, as well as to pay more than $600,000 dollars in restitution.

In court, Klundt’s attorney argued that Zachary was drunk and looking for prescription drugs, not trying to deliberately inflict damage on the clinic and its owner. Cahill doesn’t buy it: “Zachary was armed. If I had walked in there, I probably would have been dead,” she says. Two years later, All Families remains closed. “Every day I think, ‘Should I do it?’” Cahill told me. “But I don’t have the energy. I promised my family and I promised my son I wouldn’t do it. I told him I’m not willing to be a martyr. I had it, doing it alone.”

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Medical literature shows Sam Avery is not alone in deciding it’s just too risky to provide abortions. In a 2012 article in the journal Family Medicine that surveyed 113 clinicians, 54% of non-providers cited concerns from family members, or concerns about family members’ safety, as a barrier to providing medical abortions. In subsequent interviews, 21 respondents brought up living in a “region with a strong anti-abortion culture” as a deterrent.

Twenty-two, meanwhile, cited “self-motivation to overcome obstacles” as something that encouraged them to provide abortions. “In response to these extreme restrictions that are being passed, there seems to be really focused energy on doing this work as part of a service mission,” says Jody Steinauer, director of research for the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning in San Francisco. The intense controversy around abortion has made some rethink medicine’s traditionally neutral stance on politics, says Cheryl Chastine, a family physician based in Chicago and faculty member at Medical Students for Choice, a nonprofit organization with national chapters. “The people who become providers now tend to be people who come in feeling very strongly about the necessity of abortion access. They’re committed to abortion access from a socio-political standpoint.”

Raye Reeder is a member of Medical Students for Choice, and a rising third-year medical student at Oklahoma University. In May, she attended one of the group’s annual Abortion Training Institutes, learning the science and techniques that are often omitted from school curricula. Learning more about restrictions to abortion access in her state “made me really mad,” Reeder says. One recent Oklahoma bill attempted to make performing an abortion a felony, punishable by up to three years in jail. Now that there’s more controversy around abortion, certain kinds of students “are being drawn to this field,” Reeder says. “The people I’m around are getting riled up.” In 2016, applications to MSFC’s trainings rose from 228 to 321, according to Lois Backus, the organization’s executive director.

Training is crucial in encouraging people to become providers, explained Lin-Fan Wang, one faculty member teaching at MSFC’s May Abortion Training Institute, in part because these sessions “help de-stigmatize the procedure.” Nationwide, access to abortion training for ob-gyns is actually improving: In 2010, 54% of ob-gyn residency programs offered routine training in abortion, according to one survey, while in 1992, it was just 12%. But for Family Medicine residencies, it’s less than 10%, and among Advanced Care Practitioners programs, just 21% offer routine clinical training in abortion.

“When you’re murdering an innocent human being, the stigma will always be there.” — Tara Shaver of Protest ABQ, an anti-abortion group

Meanwhile, improvements in access have been geographically uneven: Of the 16% of ob-gyn residencies that offered no training in abortion at all in 2010, 60% were located in Southern states. And in Oklahoma, Kentucky, Louisiana, Missouri, Mississippi, North Dakota, Ohio, and Pennsylvania, state laws prohibit publicly-funded facilities or public employees (including medical or nursing school faculty) from providing abortions, which makes clinical training difficult.

While reporting this story, I spent weeks trying to coordinate campus visits with local chapters of MSFC in Southern

and Midwestern states, none of which panned out. The intense fear medical school PR departments and faculty displayed, simply for being publicly associated with abortion, was striking. In one case, a student who had invited me to an off-campus book club discussion (perhaps the most anodyne possible abortion-related event) pulled out at the behest of her administration. At another medical school, a training in aspiration abortion was mysteriously canceled the day before I hoped to attend.

Protest ABQ, an anti-abortion group based in New Mexico, credits its campaigns for putting pressure on abortion training at the University of New Mexico's medical school. According to spokeswoman Tara Shaver, her group's protests have included showing up on campus with posters of "abortion victim photography," placing ads in the school paper to encourage students to opt out of training, and sending postcards to city residents informing them of medical school faculty members' involvement in abortion. These campaigns don't deliberately stigmatize the procedure so much as communicate the reality of it, Shaver says. "When you're murdering an innocent human being, the stigma will always be there," she told me. "Every time someone decides not to do an abortion, it's a success."

It's precisely anti-abortion activism that galvanizes some would-be providers. Soon after finishing residency, Cheryl Chastine, then a full-time family-practice physician in Chicago, signed on to provide abortions part-time at the high-profile Wichita, Kansas clinic formerly operated by George Tiller, an ob-gyn who was killed by an anti-abortion extremist in 2009. Before Chastine began work, an anti-abortion group began staging protests outside of her Chicago employer. Chastine's bosses eventually gave her an ultimatum—stop providing abortions in Wichita or quit. She could have decided to provide abortions in Chicago instead, but "there was more need for me" in Wichita, she says.

"I just realized there was this tangible thing I could do to promote women's rights and help our society." — Holly Carpenter, nurse midwife in Alaska

In the end, Chastine quit her job in Chicago and now travels full-time to clinics around the Midwest to provide abortions. "The reason those awful tactics continue is because they work," she says. A colleague at the Wichita clinic, who was similarly targeted, pulled out before it opened and no longer provides abortions, Chastine says. "If I allowed those tactics to work, I was allowing these people whose politics I found appalling to win."

Abortion access varies widely by geography: A 2013 study found that women in urban areas with a mandatory 24-hour waiting period had a 2% chance of traveling more than 100 miles for an abortion, while women in rural areas have a 24% chance of traveling that far. Part of the problem is that primary care providers—who serve rural areas more so than specialists like ob/gyns—are less likely to receive abortion training in school. Another is that rural areas tend to be more ideologically and legislatively hostile towards the procedure.

One family medicine resident on the East Coast, who asked me not to use her name for fear of "coming off as one of those liberals who is dismissive of other parts of country," said her reluctance to provide abortions in a place like Texas is rooted more in cultural alienation than fear for her safety. "I like living in a big East Coast city. I like being able to walk out of my door and get sushi," she said. "What does it mean to raise your kids in a place where the school they might attend feels very differently about a woman's body and how she defines her personal rights of self control?"

Andrew Richard

The closure of All Families set back Holly Carpenter's plans, but it didn't dissuade her from wanting to become an abortion provider. The nurse midwife told me, "If this is the reaction that women who are seeking autonomy over their own bodies get from society, that inspires me to fight harder for them."

Carpenter, a native of Moscow, Idaho, a half day's drive from Kalispell, first read about Susan Cahill while researching abortion-related legal cases on the internet. "She's a total inspiration," she said. Later, while in school at UCSF, Carpenter got in touch with Cahill, hoping to train at All Families after graduation. Carpenter, 30, is petite, with wavy brown hair and blue eyes. She studied nurse midwifery because it seemed like the most direct, practical way to contribute to women's reproductive autonomy. "Every time I finish a birth and wash my hands from fingertips to upper arms, I have a flashback of my dad doing the same thing when he got home from a day of carpentry," Carpenter said via email.

The decisions of women she's encountered seeking abortions are similarly pragmatic. "Women have had abortions since the beginning of time. It's never been this moral argument." She recalled encounters she's had with patients. "[A woman] might say, 'I simply cannot pay for this baby.' Or maybe she's addicted to something and tells you, 'I've already screwed up this pregnancy.'"

When she visited the area around Kalispell, Carpenter liked it enough, anti-abortion billboards and bumper stickers aside. “It’s an overtly politicized, conservative environment,” she said. “But it’s also some of most spectacular country in the U.S., and it’s also where all my friends and family live.” Kalispell was also one of Carpenter’s best hopes for getting trained; in San Francisco, the clinics that train Advanced Practice Clinicians are swarmed with applicants, she says. All Families’ closing during Carpenter’s final year at USFC was a blow.

But she is far from giving up. What drew her to the job in the first place was a void of another kind. Ten years ago, “I had been really searching for how I wanted to affect change in the world. You know, graduating from college and being at a loss for what I was going to do,” she recalled. “And just realizing, there was this tangible thing I could do to promote women’s rights and help our society in general.” Today, Carpenter works in Alaska at a Indian Health Service hospital, as well as a few days a month at Planned Parenthood. After she becomes more experienced in midwifery, she plans to seek out abortion training.

Sam Avery didn’t end up going to medical or Physician Assistant’s school. Today, she is still deciding what her future holds. She currently works in a lab. “It’s a great job, but I always had high expectations for myself,” she said. “People like Susan make me notice my regrets. When I go to meet with these women I want to have something that I feel proud about that I’ve done in my life. Because I just feel so inferior sometimes.” But mostly, “It’s beautiful here and I’m happy,” she says. In the fall of 2013, Avery got married, starting the family she knew she wanted. Occasionally, Avery and her husband consider the child they could have had. But that decision is never something she regrets.

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