

GENERAL GYNECOLOGY

A statement on abortion by 100 professors of obstetrics: 40 years later

One Hundred Professors of Obstetrics and Gynecology

Forty years ago, leaders in obstetrics and gynecology published a compelling statement that recognized the legalization of abortion in several states and anticipated the 1973 Supreme Court decision in *Roe v Wade* (Supplementary Data available at www.AJOG.org).¹ They projected the numbers of legal abortions that likely would be required by women in the United States and described the role of the teaching hospital in meeting that responsibility.¹ They wrote to express their concern for women's health in a new legal and medical era of reproductive control and to define the responsibilities of academic obstetrician-gynecologists.

Since then, we have advanced the fields of reproduction and family planning. Thanks to these developments, women can now prevent pregnancy with safer and more effective forms of contraception (most recently long-acting reversible methods), with simple and sensitive hormonal and sonographic methods to determine pregnancy status and duration, and with new methods of infertility treatment and prenatal testing that rely on the option of terminating intended pregnancies that are diagnosed as abnormal. To terminate pregnancies, clinicians now use misoprostol and mifepristone for "medical abortion" (which in 2009 accounted for 16.5% of terminations in the United States and can be office-based) and use sonographic guidance of intrauterine procedures along with new methods for inducing cervical

In this Journal in 1972, 100 leaders in obstetrics and gynecology published a compelling statement that recognized the legalization of abortion in several states and anticipated the 1973 Supreme Court decision in *Roe v Wade*. They projected the numbers of legal abortions that likely would be required by women in the United States and described the role of the teaching hospital in meeting that responsibility. They wrote to express their concern for women's health in a new legal and medical era of reproductive control and to define the responsibilities of academic obstetrician-gynecologists. Forty years later, 100 professors examine the statement of their predecessors in light of medical advances and legal changes and suggest a further course of action for obstetrician gynecologists.

Key words: abortion, law, teaching hospital

dilation and uterine contraction; patients benefit from innovations in counseling and new approaches to pain control.²⁻⁶ Studies of abortion practice and outcomes are also much more sophisticated than they were 40 years ago.^{7,8}

We have had 40 years of medical progress but have witnessed political regression that the 100 professors did not anticipate. In 2011 alone, 24 states passed 92 legislative restrictions on abortion.⁹ Waiting periods after consent are now law in 26 states. Alabama, Arizona, Florida, Kansas, Louisiana, North Carolina, Oklahoma, and Texas require patients to view ultrasound images and, in Arizona, Louisiana, Mississippi, and Texas, to listen to fetal heart beats.¹⁰ Laws in 27 states force physicians to provide deceptive counseling including false statements about risks of breast cancer, infertility, and mental health. They include laws to limit second-trimester abortion under the guise of protecting the fetus from pain (Alabama, Idaho, Indiana, Kansas, Louisiana, Nebraska, and Oklahoma).¹¹ Laws directed specifically at medical education in Arizona, Kansas, and Texas prohibit abortion training in public institutions and another 7 states ban abortion in public hospitals, precluding training in them.¹²

What vision of the future of legalized abortion did the 100 professors have?

How accurately did they estimate the need for safe, legal abortion and anticipate their colleagues' willingness and commitment to meeting it? They wrote, "In view of the impending change in abortion practices generated by new state legislation and federal court decisions, we believe it helpful to [respond] to this increasingly liberal course of events...by contributing to the solution of an imminent problem."¹ Forty years later, the change is not liberal. Its effects will threaten, not improve, women's health and already obstruct physicians' evidence-based and patient-centered practices. We review our predecessors' 1972 statement and judge how it compares with what actually occurred and with legislation that has been adopted over the 40 years since their writing and the passage of *Roe v Wade*.

The 100 professors were remarkably prescient in anticipating the need for 1 million legal abortions and today's abortion rate of 1 in 4 pregnancies.^{13,14} They predicted that teaching hospitals with specialized outpatient facilities could meet the demand and believed that abortions were the responsibility of hospitals. But today, 90% of abortions, which include the 10% that are in the second trimester, are done away from hospitals.¹⁵ Many hospitals enforce fetal and maternal health restrictions that

From the 100 Professors (Appendix).

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are not based in the law but are contrived and enforced by the same kind of “ethics committees” that were common before the professors’ 1972 statement.¹ Some institutions offer terminations only to save a woman’s life; others will perform the procedure under no circumstances at all. At the same time, many states have passed legislation to shut down the freestanding clinics that are now responsible for most abortions by enacting cumbersome and expensive building regulations that are disguised as patient safety requirements.¹⁶ There are now 25 states that, under the guise of patient safety, restrict abortions to hospitals that have their own restrictions or to specialized facilities.

In our view, hospitals have disregarded the responsibility that our academic predecessors expected them to assume. Although most first-trimester and many second-trimester abortions can be done safely and efficiently in a clinic setting, some second-trimester abortions, particularly those that are complicated by medical conditions, should be done in a hospital with rapid access to the operating room, interventional radiology, blood bank, and other emergency interventions.¹⁷ Hospitals and expert clinicians are essential for the education of students and training residents who care for complicated cases and for treating complications.

The 100 professors went on to say that physicians should learn uterine aspiration, which is an outpatient procedure that today accounts for 82.3% of abortions, and local anesthesia and analgesia, which includes conscious sedation, so that complications and expense of general anesthesia would be reduced.⁶ Today, some hospitals confine pregnancy termination, even routine first and uncomplicated second-trimester spontaneous and induced abortions, to operating rooms and have credentialing rules that prohibit the use of conscious sedation for these patients.¹⁸ Ignoring the 100 professors’ counsel not only dramatically increases patients’ recovery time and expense, but also adds significant and unnecessary staffing and clinical costs that discourage hospitals from providing abortions at all.

Regarding hospital policies and the role of “abortion committees,” the 100 professors wrote “therapeutic abortion boards will have no place...in states with laws which stipulate that abortion decisions are to be made by the physician and his [her] patient.”¹ The 100 professors commented on the physician’s duty to counsel regarding abortion: “There are patients...who should be actively encouraged to consider abortion—for example, women who are unaware of a teratogenic threat to their pregnancies.” At that time, the professors would have been thinking of rubella and did not know that advances in prenatal diagnosis would give obstetricians the opportunity and responsibility to make their patients aware of a wide range of genetic anomalies and to offer abortion if requested. The 100 professors certainly would not have envisioned the legislation recently proposed in Oklahoma to entitle physicians to withhold information in cases of known fetal deformity because a knowledgeable patient might choose termination.

Writing about doctors with conscientious objections, the 100 professors said that these physicians must be excused from performing abortion but must refer patients to colleagues who can care for them. Recent “conscience clause” legislation does not require referral for abortion, and some states (Colorado, Ohio, Wisconsin, Michigan, and Texas) specifically prohibit referral for abortion by physicians who work in institutions that receive state funding for women’s health services.¹⁹ The American College of Obstetricians and Gynecologists, which discussed the limits of objection, recommends that “Any conscientious refusal that conflicts with a patient’s well-being should be accommodated only if the primary duty to the patient can be fulfilled.”²⁰ Despite this guidance, many physicians are now prohibited by law from referring patients to vital services. In Texas, for example, referral for abortion can result in denial of contraceptive funding.

The 100 professors predicted that space and resources for hospitals to provide abortion would result from “...the lessened number of septic abortions.”¹

The Centers for Disease Control and Prevention and others subsequently documented a steep decline in hospital admissions and morbidity and mortality rates from illegal abortion promptly after *Roe v Wade* made abortion legal in all the states.²¹

The savings in lives and money from legalization were soon forgotten, and many hospitals now claim they cannot afford to provide abortions even if they wanted to because, among other arguments, reimbursement rates are too low (but abortion is certainly not the only service in this category), free-standing clinics provide faster and cheaper services with which hospitals cannot hope to compete (but some hospitals are able to provide cost-effective abortions), and hospital employees, notably nurses, refuse to provide abortion care (unlikely true of all or most nurses).

Some hospitals with abortion services still face legislative challenges. Even though many residency programs have integrated abortion training successfully, individual states and, recently the US Congress, have legislated restrictions on abortion training in disregard of Accreditation Council on Graduate Medical Education training mandates.^{22,23} These restrictions ultimately threaten women’s health by denying residents training in uterine evacuation, which further reduces access to safe abortion.

The 100 professors considered the consent process for abortion, stating that “...it has been ruled by [some] courts that an adult woman is free to make this decision by herself.”¹ However, several state legislatures have interfered in the consent process by requiring that irrelevant, even untrue, information be given by the physician (eg, abortion causes breast cancer and fetal pain) and enacting burdensome waiting periods that increase risks and costs.^{9,11} They further predicted “that the courts will someday decide that “any girl who is physically mature enough to conceive should, ipso facto, be granted the freedom to determine the fate of her pregnancies.” Yet politicians in 37 states have restricted freedom of access of minors to abortion by implementing parental consent or notification laws,

often with clumsy, prolonged “judicial bypass” requirements that lead to dangerous delays.²⁴

The professors addressed the need for postabortion contraception to decrease the need for abortion, endorsing it as “an integral part of any abortion program,”¹ but today the most effective contraceptives are still not easily accessible immediately after abortion when women most want them. Although the American College of Obstetricians and Gynecologists, Planned Parenthood, and other organizations promote post-abortion use of long-acting reversible contraception, the family planning funding regulations of many states do not pay for immediate postabortion methods, and several states (eg, Indiana and Texas) and the US House of Representatives have attempted to eliminate family planning from their budgets entirely.¹⁹

Finally, the 100 professors recommended that “abortion should be made equally available to the rich and the poor.”¹ Ironically, shortly after the 1973 *Roe v Wade* decision that our predecessors anticipated, the Hyde Amendment prohibited the use of federal dollars for abortion so that women in the military or who have received Medicaid have had severely limited access to abortion for nearly 40 years, unless they can pay themselves or happen to live in one of the 13 states that use their own funds for abortion.²⁵ Richer women, on the other hand, usually have private health insurance for abortions but there, too, the US Congress threatens women’s health by insisting that the Affordable Care Act restrict even private payers from directly including abortion.

In consideration of current legislative threats to the autonomy of our patient relationships, to evidence-based medical practice, to the training of our students and residents, and ultimately to the health of our patients, we 100, including 2 of the original signers, join the 100 of 1972 in affirming our academic responsibilities to (1) teach future practitioners about all methods of contraception and about uterine evacuation throughout pregnancy, which ranges from miscarriage

management to emergent evacuations and the treatment of complications in accordance with our professional mandate from Accreditation Council for Graduate Medical Education; (2) provide evidence-based information to all patients who seek family planning or pregnancy termination; (3) provide evidenced-based information to legislators who propose laws requiring inaccurate information or unindicated procedures for women seeking to terminate a pregnancy; (4) insist that the hospitals where we care for women and teach students and residents admit patients who require hospital-based pregnancy terminations, and (5) ensure the availability of all methods of contraception, particularly long-acting reversible contraception methods, to reduce the need for abortion. ■

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