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

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.AJOB.org). 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.

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 dilation and uterine contraction; patients benefit from innovations in counseling and new approaches to pain control. Studies of abortion practice and outcomes are also much more sophisticated than they were 40 years ago.

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. 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. 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). 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.

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.” 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 comport 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. 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. 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 con-
trived 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 cir-
cumstances 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 hos-
pitals that have their own restrictions or
to specialized facilities.

In our view, hospitals have dis-
regarded the responsibility that our ac-
edemic 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 com-
plicated by medical conditions, should
be done in a hospital with rapid access to
the operating room, interventional radi-
ology, blood bank, and other emergency
interventions. 17 Hospitals and expert cli-
nicians 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 aspira-
tion, which is an outpatient procedure
that today accounts for 82.3% of abor-
tions, 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 preg-
nancy termination, even routine first and
uncomplicated second-trimester sponta-
aneous and induced abortions, to oper-
ating rooms and have credentialing rules
that prohibit the use of conscious seda-
tion 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 physi-
cian and his [her] patient.” 1 The 100
professors commented on the physi-
cian’s duty to counsel regarding abor-
tion: “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 legisla-
tion recently proposed in Oklahoma to
entitle physicians to withhold informa-
tion in cases of known fetal deformity
because a knowledgeable patient might
choose termination.

Writing about doctors with conscien-
tious 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” legisla-
tion does not require referral for abor-
tion, and some states (Colorado,
Ohio, Wisconsin, Michigan, and Texas)
specifically prohibit referral for abortion
by physicians who work in institu-
tions that receive state funding for
women’s health services. 19 The American
College of Obst�etricians and Gynecolo-
gists, which discussed the limits of
objection, recommends that “Any con-
scientious refusal that conflicts with a
patient’s well-being should be accom-
modated 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 pro-
vide abortion would result from “…the
lessened number of septic abortions.” 21
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 argu-
ments, reimbursement rates are too low
(but abortion is certainly not the only
service in this category), free-standing
clinics provide faster and cheaper ser-
vices 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 ser-
vice 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 Accred-
itation 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 re-
duces 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.” 21 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,” 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 postabortion 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.”25 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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