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Anomalous* Experience of a Family Physician

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**Anomalous: deviating from a general rule, method or analogy, e.g. position of the free Negro in the Slave states.*

—Webster's 3rd International Dictionary

Abstract—Abortion is the most frequently performed surgical procedure in the United States—between 1.2 and 1.5 million annually—and it is one of the safest when done properly. Yet few family physicians or gynecologists commonly discuss or offer it.

A woman having an unintended and/or unwanted pregnancy experiences considerable emotional stress and often finds little support from family or friends. Frequently she travels long distances alone to have an abortion. After abortion there may be a sense of loneliness and misgivings, instilled by rhetoric and billboards of anti-abortion groups in the community. In this atmosphere, a woman rarely informs her primary caregiver, who, if trained, might provide for her needs in an empathic, familiar, and positive environment.

Physicians infrequently have the opportunity to be trained to provide abortion in their practices; yet, if trained they can contribute significantly to the health and privacy of women and families. The author has been performing abortions as part of his family medicine practice in Montana for 30 years and is the sole provider in NW Montana within a radius of 100 miles and for a population that has grown from less than 100,000 to over 200,000 in this period. This paper will present data and experiences derived from this practice.

Keywords: medicine—anomalous medical experience—population data—abortion

Preamble

It is a distinct privilege for me to make a presentation to the Society for Scientific Exploration (SSE). I am afforded this privilege by being the local organizer for this meeting. When I considered whether I had anything to offer the Society, it was apparent that the unique aspect of my practice of Family Medicine is the inclusion of abortion since the *Roe v. Wade* decision in 1973 by the US Supreme Court. I believe my proposal was considered somewhat hesitantly by the Program Committee out of concern that it could become a distracting focus of controversy, just as it has been for me for some years. Nonetheless, the Mission Statement of the Society does refer to *''improved understanding of those factors that unnecessarily limit the scope of scientific inquiry, such as sociological constraints, restrictive world views''*... and furthermore, *''the Society does not endorse nor exclude any particular topic of research.''*

So, I am reassured and find some satisfaction doing something that has repeatedly been rejected by the Education Committee of the Medical Staff of Kalispell Regional Hospital, even though our office was a satellite site for a 3-year nationwide study of mifepristone (RU-486; the "French abortion pill") before it was released in this country in 2001. Perhaps if SSE had gone to Galileo's community, Galileo would have felt more appreciated when dealing with the church. And abortion also is a church-provoked controversy.

Introduction

Abortion is unique among medical services in that it has been segregated from the usual practice of medicine and surgery into clinics, which function in assembly-line fashion to provide this sole service. Clinics provide 93% of abortions in the United States even though they represent only 46% of all abortion providers. In 1977, because abortions were not being done in other practices in Kalispell, I employed a woman Physician Assistant to help do abortions as well as deliver family-practice services. Our office has provided a full family practice including general medicine, pediatrics, geriatrics, obstetrics, and minor surgery, and we incorporate abortion services simply as another part of the daily routine. We have provided approximately 9,000 abortions in this model since 1973, which amounts to about 7% of patients cared for. A woman making an appointment for an abortion is scheduled just as for any other service, plans to spend 60–90 minutes in our office for her procedure, and may drive herself home.

We have kept a log of all our abortion procedures, and this presentation will include a retrospective review of some of these data along with an overview of pregnancies and abortions in the United States, some historical and sociological observations, and some personal remarks about my experience, attempting to provide some insight into *''those factors that unnecessarily limit the scope of scientific inquiry''* or, in this case, of evidence-based medical practice.

When I began to perform abortions in 1973, they had already been legalized in the state of Washington for 3 years, prior to *Roe v. Wade,* by public referendum, and the physicians in Kalispell who might also be involved agreed we should have them available here. I was particularly interested because of my experiences in medical school and residency in New York during the 1950's, when it was a daily experience to care for women who were having serious complications from criminal abortion and attempts at self-induced abortion, which also was a criminal offense. I remember particularly a woman in her mid-20's whom I admitted to the hospital with an undiagnosed infection, who died 2 days later. We had discovered that she had had an abortion and had notified the police as required. I remember her distress, and mine, when she was interrogated by 2 male detectives, and I remember the agony of her death only 3 or 4 hours later.

I also remember assisting a distinguished and gentlemanly surgeon perform a hysterectomy supposedly for a fibroid uterus. The woman was in her 40's, and as a young intern I was startled when I realized that this was a solution to an unwanted pregnancy for a woman in more affluent circumstances.

Before reviewing some of my own data, here is a brief picture of relevant data for the United States from the Alan Guttmacher Institute in New York City, which is the primary source in the United States for abortion and reproductive data (see References below).

- There are approximately 6 million pregnancies annually in the United States, of which more than half are unintended. There are about 4 million births and about 1.3 million abortions, the remainder being miscarriages (these actual numbers are for 2000, the most recent year reported).
- 44% of US women have at least 1 abortion in their reproductive lifetime.
- 87% of US counties have no abortion provider.
- There are about 340 abortions for every 1,000 live births on an annual basis in the United States. In 1990 this ratio in Montana was at a peak of 295 and is now dipping near to 215. The national ratio, while higher, is following the same trend. It is interesting to note that the Montana birth rate in 1990 was approximately 15 per 1,000 population, and this has dropped to 12.1 per 1,000 in 2001, which is among the lowest rates in the nation. During this same time period, the US birth rate dropped from approximately 16.5 to approximately 15 in 2001.
- Our office provided 513 abortions in 1990 and 232 in 2002. The number in 1990 was inflated by over 100 women from Alberta, Canada, at a time when that province was restricting payment for abortion to hospitals.

Data

The following gives a picture of the abortion part of our practice in 2002 and of the women we served.

The consent form (Figure 1) defines the technical information provided to each woman who has an abortion. This is done face-to-face by the physician or physician assistant, who takes the history and performs the examination and procedure and gives follow-up instructions. We ask every woman to return in 2 weeks for a follow-up examination and contraceptive evaluation at no additional charge, but only 60% take advantage of that, despite follow-up phone calls when the appointment is missed and letters to referring physicians when patients come from outside our area. But in clinics only 30% return for follow-up.

Table 1 shows the age distribution of the women and data about parental notification in the case of teen-agers. Fifty teenagers (age 19 and younger) had abortions in 2002, which is 22% of our total and reflects a proportionate reduction from approximately 30% in 1990. The Alan Guttmacher Institute

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The undersigned hereby agree, request and consent that an abortion be performed on _____ by James H. Armstrong, M.D., or his Physician Assistant, Susan Cahill, PA-C. We understand that the purpose of this operation is to terminate pregnancy. We have been informed of and have discussed:

a. the estimated stage of development of the fetus;

b. the method of abortion to be utilized;

c. the effects of abortion on the fetus;

d. the physical and psychological effects, including possible complications, such as retained tissue, missed abortion, hemorrhage, infection, perforations, ectopic pregnancy, and others, which could require surgery, result in loss of ability to have children, or, very rarely, even result in death;

e. the available alternatives to abortion;

f. the necessity to return for abortion if a dilator is used; and

g. that I should take no alcohol, drugs, nor medications, including aspirin, for two weeks, unless prescribed by my doctor.

_____ _____

_____

Dated in Kalispell, Montana, this ____ day of _____, _____.

Rev. 01/2000

Fig. 1. Consent form.

TABLE 1
Number of Girls and Women per Age Group Having Abortions with Parental Notification

Age	Number
12	0
13	0
14	2
15	4
16	4
17	11
Total <18	21[a]
18	14
19	15
Total teenaged	50
20–25	91
26–35	65
36+	26

[a] Of these 21, 1 was emancipated. Seventeen of the remaining 20 informed at least 1 parent.

reports this reduction as a national trend and ascribes it to better sex education, increased contraceptive use, and, to a lesser degree, abstinence.

Only 3 of the 20 unemancipated girls aged 17 years or younger did not inform at least 1 parent, which is comparable with our experience in the past. The Montana Constitution provides for the privacy of juveniles. It is our sense that most girls not telling a parent have a good reason not to.

Of 232 women provided abortions in 2002, 129 (about 55%) already had a child or children, and 46 (about 20%) were married. Thus, about 80% of our patients having an abortion are not married. It is interesting to note that in 2001, in both Montana and the rest of the United States, approximately 32% of births were to unmarried women. This is an increase in Montana from 12.5% in 1980 and 23.7% in 1990; in the United States, from 18.4% in 1980 and 28% in 1990.

Thirty women reported their religious affiliation as Roman Catholic and 29 as Protestant, about 13% of the total in each case. We believe these figures are under-reports and that many women are uncomfortable revealing their religious affiliation when having an abortion.

Table 2 shows that no less than 37% of women having an abortion have had at least 1 prior abortion. This is the same as for Montana as a whole in 2001.

TABLE 2
Number of Women Who Had Previous Abortions[a]

Previous abortions	Number of women
1	57
2	20
3	9
4	1

[a] From a total of 232 women.

TABLE 3
Reasons for Wanting an Abortion[a]

No children wanted, or no more children wanted	62
Children not wanted *now*	60
Contraception failure	50
Unmarried	47
Financial	41
Marital discord	40
Age	39
Career interference	25
Rape	5
Pregnancy not by husband	4
Maternal medical indications[b]	3
Possible fetal abnormality (Down's syndrome [1], heavy drug use [1])	2
Incest (father-daughter and brother-sister have been seen)	0

[a] The 232 women reported 378 reasons for having an abortion.
[b] Though infrequent, they are varied and significant. In 2002 these 3 were Maternal Factor V excess and deep venous thrombosis, anorexia nervosa, and juvenile diabetes.

Of the 227 women who responded to the question, 189 (83%) reported feeling OK or indifferent about having an abortion. Thirty-seven (16%) reported mixed feelings, only 1 felt "bad" about it, and none felt "very bad". While anti-abortion rhetoric, trying to create a stigma, is reflected by some women who are apprehensive about the procedure, most women evidently come to grips with their decision and are firm in it. During the Reagan administration, Surgeon General Dr. Koop could find no evidence of significant post-abortion emotional disturbance. No doubt the White House was quite disappointed.

The reasons for having an abortion are shown in Table 3. Women often have more than 1 dominant reason for their decision to have an abortion. Those who did not want children at that time frequently cited their own immaturity or inadequacy within their present circumstances.

Contraceptive failure was reported as a reason in 50 cases. The failing methods are shown in Table 4. Tubal ligation failures also occur. It seems to be a common ruse for a man who does not want to use a condom to tell a woman that he had a vasectomy or that he is sterile.

TABLE 4
Types of Contraceptive Failure

Condom	26
Birth-control pills	16
Rhythm method	2
Spermicide	2
Vasectomy	2
Depo-Provera[a]	1
Withdrawal	1

[a] Trade name of a hormonal contraceptive given by injection at 3-month intervals.

TABLE 5
Number of Abortions per Gestation Period[a]

Weeks of gestation	Number of abortions
≤8 (first trimester)	122
9–14 (first trimester)	76
15–19	26
20–23	8

[a] Gestation was calculated from date of onset of last normal menstrual period.

Nationally, 50% of abortions are performed by 8 weeks into a pregnancy, and 90% by 12 weeks. Fewer providers are available for more advanced gestations. More women are choosing medical abortion (RU-486) prior to 9 weeks, but it is more inconvenient, and in 5–10% of cases it requires further care—i.e., surgical suction. My own experience for 2002 is reported in Table 5. Of the 232 abortions, only 15 were induced medically by RU-486. One hundred ninety-eight (85%) of the 232 procedures were done in the first trimester.

Complications are rare. Minor "complications" are usually handled with a phone call or a brief office visit and are not counted under the Clinical Policy Guidelines of the National Abortion Federation. Only 4 significant complications were encountered in 2002: 1 post-abortal hematometra[1], 1 missed abortion, 1 perforation, and 1 "toxic shock" following medical abortion. Only the perforation required hospitalization. (We have had only 2 perforations in our 30-years experience.) The toxic shock was treated very early before the diagnosis could be established definitively.

A serious concern for abortion providers is that when a post-abortion patient with a minor problem sees a physician not trained in abortion (which includes the majority of specialists in obstetrics-gynecology), major and expensive problems develop. If the physician is opposed to abortion, the situation is even worse.

Discussion

Abortion is discussed in a variety of contexts: religious, moral, psychological, and demographic. Figure 2 is relevant to the latter concern. It is estimated that there are 50 million abortions yearly in the world, so without abortion the world would have added and would continue to add 1 billion persons to the population every 20 years.

The World Health Organization (WHO) estimates that 78,000 women die yearly from abortion in developing countries where it is illegal, and untold more suffer serious complications. For example, in Brazil, a predominantly Catholic country, it is estimated that 6 million illegal abortions occur yearly.

WHO also reports that about 11 million children under 5 years of age die annually from malnutrition and neglect. That would be about 30,000 daily.

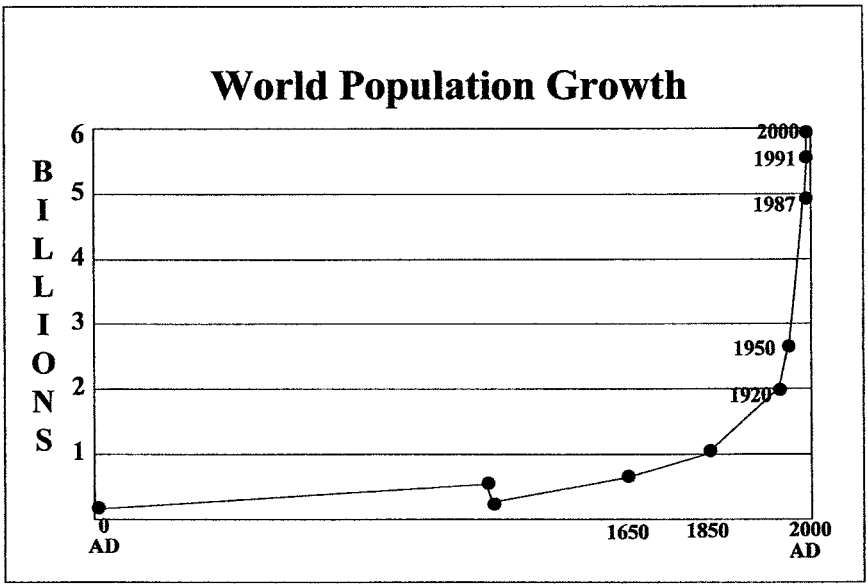

Fig. 2. World Population Growth—The implications of the graph are obvious. It is estimated that there are 50 million abortions yearly in the world, so without abortion the world would have added and would continue to add 1 billion persons to the population every 20 years.

Regardless of these compelling social issues, as a physician I also found it necessary to answer an ethical issue for myself and for our patients, essentially: What is the value of a fertilized egg, of an embryo, of a fetus?

Throughout history, there does not appear to have been a general consensus—not on scientific, legal, philosophical, or religious grounds. Even Hippocrates is said to have advised a dancer to follow a certain regimen to cause herself to abort. Aquinas and Augustine followed Aristotle's lead, holding that abortion during the first 6 or 8 weeks of pregnancy was at least not murder; and the Roman Catholic Church did not equate early abortion with murder until 1869. The Right to Life Organization—founded and maintained by the Roman Catholic bishops of the United States (who also oppose contraception and coitus interruptus)—is trying to create laws establishing that a fertilized egg having a full set of chromosomes (even if some of those chromosomes are incompatible with life) is a human being with full right of personhood. The conservative and fundamentalist Protestant churches also equate abortion with murder.

The rhetoric of the various anti-abortion groups and the publicity they create has evoked and supported violence, including 8 murders and numerous terrorist events against abortion providers in the United States. This was markedly exacerbated during the Reagan administration until, during Reagan's second term in office, FBI Director William Webster persuaded Reagan to speak against the violence.

In addition to the usual picketing at the office and anti-abortion letters to the editor, this author has experienced repeated picketing and prayer vigils at his home and church. "WANTED" posters were put up around the community, and in 1994 arson caused over $200,000 damage to our office.

Nonetheless it was not all bad. Following the arson the medical society took a full-page ad in the local newspaper that listed the names of over 100 local physicians opposing the violence. A rally and parade of 300–400 people down Main Street was a spontaneous grass-roots demonstration of support.

From our experience, the view evolved that the value of a pregnancy prior to viability of the fetus depends predominantly on the woman's commitment to the pregnancy. In gaining informed request/consent from each woman, we explore how she feels in general about abortion, and whether she has any religious affiliation. Thus, we can develop some confidence about her emotional circumstances in respect to her decision. In our perspective, this is the most important consideration for the woman having an abortion. The procedure is 5–10 times safer than carrying the pregnancy to term, takes only a few minutes, and is accompanied by brief and little or moderate discomfort. It is rare for serious psychological effects to occur; we suspect there is more attached to giving a baby up for adoption.

The rhetoric of anti-abortion groups in our opinion does more than anything else to create misgivings in women having had an abortion. The effusive, self-righteous, intimidating religiosity of fundamentalism is increasingly prevalent in our society and worldwide in most religions. The independence and equality of women appears to be a primary threat to fundamentalist religions and the Roman Catholic Church. This is manifested by the prominence of abortion and sexual issues in their concerns. Could it be that these male-dominated worldviews have an innate fear of the physiological, intellectual, emotional, and spiritual differences of women?

Abortion remains a controversy at the intersection of 3 primary world issues: the health, welfare, and equality of women; the population explosion; and advancing fundamentalism in US political leadership and in world religions. Such fundamentalism impedes progress toward a consciousness that can lead to a united world that allows for equality and differences without war.

Abortion will remain necessary and will be obtained, legal or not, as a back-up to contraception for the unintended and unwanted pregnancy. It is preferably provided by a woman's personal physician, simply and with support and compassion.

Note

[1] Hematometra is the uterine retention of bleeding following an abortion. Blood fills the uterus and may become quite painful until it is expelled or usually removed by suction. The cause is uncertain and the chief problem is primarily pain.

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