IN SICKNESS AND HEALTH

Choosing

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Rameesha first came to my family medicine practice when she was 22 years old having immigrated to New York 4 years previously to attend school. A few months earlier, she had married her college sweetheart, a man from her Middle Eastern country. She told the nurses that she was just coming in for a "checkup." Despite her nods and shy smiles, her demeanor suggested an undertone of worry. I had difficulty understanding because of her accent and halting, formal English. Finally she said, "But why I am not yet pregnant?"

This was the real reason she wanted me a checkup. I questioned her about the relevant medical background. Her husband was her first partner. She never had any sexually transmitted diseases and was pretty sure he hadn't. Her menstrual cycles were normal. I examined her slowly, talking her through it and explaining her anatomy with a mirror because it was her first pelvic exam ever. Her exam was completely normal, I told her. The Pap smear and culture results would be back in a few days. As long as they were also normal, she needn't worry; couples take an average of 6 months to become pregnant from the time they start trying.

I tried to find out who was pressuring her. Her husband? Parents? In-laws? I care for women from a range of cultures, even some with husbands who have several wives. There are groups that value highly the wife with the most children. I feared that this was the pressure she was facing and tried to ask delicately about it. No, it seems he was more modern. He just wanted a baby and expected it to happen quickly. I explained what I could about ovulation, timing intercourse, and recommended some readings. I had other patients waiting, so I suggested she come back in 2 months with a basal body temperature chart.

My family practice attracts a population as diverse as New York City. Located near a major subway stop, we get patients from both the surrounding neighborhood in lower Manhattan and from the rest of the city. As one group of family doctors in a nonprofit network of clinics, we see HMO, Medicaid, and uninsured patients, and are affiliated with a well-respected family medicine residency program. I divide my time among seeing patients in our office, giving lectures, and one-on-one teaching of medical students and residents at our local Planned Parenthood. The teaching and patient care provide a nice balance. In response to the ever-present pressures to see more patients more quickly, I often

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find myself making intermediate plans with patients and asking them to return for further evaluation. Luckily, many problems sort themselves out by the time the patient returns and extensive workups become unnecessary.

So it was with Rameehsa. When she came back 6 months later, she requested a pregnancy test because she'd missed her period for a few weeks. When I first saw the chart on my door with a positive pregnancy test, I braced myself. So often this is not good news for patients because the pregnancies are unplanned and unwanted. It also had caused me to practice in a way that didn't feel right. I wanted to be able to provide care for all my patients' needs. If the patients elected to continue their pregnancies, I could provide prenatal care. But if they decided on an abortion, all I could do was refer them to Planned Parenthood for a termination. It felt as if I were giving them a subtle message of disapproval: I would care for them only if they wanted their pregnancies, and send them away if they did not.

Here was a patient, though, I thought would be happy with the news. I usually ask an unbiased question when I enter the exam room, just in case: "Did you think your test would be positive?" "Oh, yes! I have been so sick!" Rameesha answered with a big smile, bringing her hands together in some gesture between a clap and a prayer as she looked to the sky as though to give thanks. We discussed her options for prenatal care, and she decided to come to me. I explained my preference that her husband should accompany her; and she promised, with a doubtful look, to try to bring him.

I am used to the range of attitudes among patients in New York, including some who see the prenatal visits and childcare as the woman's arena. I keep the door open for women who prefer support in sharing this role, however incremental it may be. Unlike some women from her culture, Rameesha usually traveled on her own to my office for her visits rather than under the escort of her husband. I did meet him once. He was quiet and reserved but seemed pleased with himself and with her because of their impending family. I offered our childbirth education classes and asked about their plans for childcare. She would stay home with the baby, and her mother would come for the first month. Other supports? Other friends with young children or expecting some soon? Perhaps a sister would come for a visit when the mother went home. Rameesha seemed to have few friends, and depended on her husband for most of her social life. I wasn't sure if I was stepping on cultural toes here, but I encouraged her to go to the childbirth education classes and make friends with other women who would also be new moms.

A few months later, I was disappointed to hear that she had decided to change her prenatal care to a hospital closer to home. This is not unusual for us. Women often worry about whether they will "make it" to our hospital on time if they have to travel by subway. I figured that I would probably not see Rameesha until after she gave birth, but as it turned out, she began seeing a pediatrician locally after her baby was born.

More than a year passed before I saw her again. She came in with her 8-month-old boy, appearing to be quite proud of him, but also looking very frazzled. He had been having ear infections repeatedly, and she was coming to me for help. I advised her on all of the usual preventive measures, many of which were unfamiliar to her. Then I asked about her. She had not been sleeping; the baby had awakened many times during each night and she had to nurse him back to sleep repeatedly; her husband was working long hours, and she was home alone with a fussy and demanding child. She was isolated and exhausted. When I started to feel overwhelmed by her visit, I took it as a clear sign that she was overwhelmed by her life.

I listened empathetically and suggested she come back in 2 weeks to let me see if the measures I recommended for his ears were effective. I wanted more time to talk with her about her. At the last minute I remembered birth control. She said they weren't having sex because the baby was sleeping with them, and she was too tired anyway.

She came back 6 weeks later and reported that the baby had been doing better. She, however, looked burned out. I could see why. He was very clingy and would not sit in his stroller, even for a minute, so that we could talk. She was not involved in any childcare groups, did not spend time with any adults other than her husband, and was clearly having trouble figuring out how to take care of this baby. She had not had a postpartum exam and was not using birth control. I was pleased to see her. She did have to travel a long way and I thought that her coming to my office meant she knew she needed help. My plan was to take care of as much as I could and then introduce her to our social worker for more help. I checked the baby quickly and praised her for taking such good care of him. She brightened. This kind of feedback was not what she was getting in her day-to-day life. I then suggested that we do her postpartum exam and discuss birth control methods. She looked relieved at that suggestion; I took this as a sign that they were at least having sex again.

Usually we let one of our medical assistants play with a baby while we do a mother's exam, but this baby was having none of that. So I did her exam with him on her lap. Later, while the baby still demanded her attention, I tried to talk with her about contraception. She chose pills and took a prescription with her. I asked her to come back to get the results of her tests, something I rarely do, because I wanted to make sure she was all right. In the back of my mind, I was worried she might be having postpartum depression. I later spoke with her social worker who thought Rameesha's social isolation was the larger issue. She told me that she had made suggestions to her about neighborhood centers with programs for young moms and babies.

To my surprise, Rameesha came back 3 weeks later on an "urgent care" visit. Her period was late, and she was feeling pregnant. She looked stricken. "It is too much," she mumbled over and over with her fussy baby on her hip. I sympathized and we talked while we waited for the results of her pregnancy test. Her husband wanted more children. She wanted more too—but not so soon. This baby was so difficult for her; she didn't know how she could manage another one in the near future. The medical assistant brought in the result of the pregnancy test: positive.

Rameesha started to cry. Her husband would never approve of an abortion; she could not even get to one of those clinics without his knowing. She was trapped, but she could not bear this! I interrupted her, sensing impending hysteria. I explained how I might help.

Two-and-half-years ago, my colleagues and staff had started talking about offering early first-trimester surgical abortion procedures in our facility. At first, the staff had mixed reactions to these discussions. Some staff members were incredibly supportive, especially a 58-year-old clerical assistant who,when she was a teenager, had seen a friend die from an illegal abortion. To my surprise, she was open to talking at length to everyone about what she had lived through, and the importance of keeping abortion safe, legal, and accessible. Others were afraid we would become targets of violent anti-choice protesters. Some had moral objections. We held staff meetings, "values clarification workshops," and just talked a lot. This helped most of us move to a place where we could see our roles as professionals, to help our patients whatever their choices, and not to let our personal values intrude.

I went to Planned Parenthood to receive training on doing early suction procedures. I had high hopes that I could offer early first-trimester abortion as part of my practice; but bureaucratic New York State regulations got in the way. Because we are an "article 28 facility," we were required to file an amendment to our operating certificate if we wanted to add a service such as abortion, a process that would be long and arduous. There were other barriers to contend with, such as high malpractice insurance costs and limited insurance reimbursement for family physicians. We appeared to be stymied.

Then on September 28, 2000, the Federal Drug Administration approved the use of mifepristone, better known as RU486 or the "French abortion pill," *without restrictions its use by primary care doctors*. The New York State regulatory requirements needed for suction abortions did not apply to giving a pill, our legal consultants assured us. We could offer this new medical abortion to our patients.

It took months of red tape to order the pills. (At $90 per pill, my health center administration wanted a cost analysis done to make sure we would not lose money.) We learned about the protocol for using mifepristone from family doctors in New York who had been part of the Abortion Rights Mobilization trials (Schaff & Fielding, 2000). We consulted with radiologists about doing "limited gestational sonograms" for these patients. They refused. They would only do the "full pelvis" and charge for it! While sonography was optional, I was nervous in the beginning and wanted to take every extra precaution. We leased a sonogram machine. The staff members were leery in the beginning as well. They feared protestors and angry spouses or parents. We held more discussions at staff meetings. A small number of staff—some who had been unhappy with other aspects of their jobs as well—decided to find work elsewhere. Having overcome all the bureaucracy and resistance, we finally went ahead and began offering the abortion pill about 4 months before Rameesha learned of her second pregnancy.

To me, she exemplified the reason why abortion needs to be available in women's own doctor's offices. Her husband knew her whereabouts at all times. She could not go discretely to an abortion clinic and, even if she could, she had no one to watch her baby. Too many women like her would simply not have access to this service if they had to go to specialized clinics, because of the stigma, the protestors, and the lack of privacy. Since I had started offering abortions by means of the newly approved pill, quite a few women came to me for it because it was a way to hide it from a partner. This method provided privacy in ways I had not anticipated.

I explained medical abortion to Rameesha. I would give her the mifepristone pill in my office. I told her this would cause the pregnancy to detach and stop developing. Then, 24 to 72 hours later, she would insert four other tablets (misoprostol) into her vagina that would cause cramping and heavy bleeding, similar to a miscarriage. I also had to explain that this was not the same as the FDA labeling for mifepristone, but that it was a newer protocol that had been shown to have higher efficacy and fewer side effects (Newhall & Winikoff, 2000; Schaff, Eisinger, Stadalius, et al., 1999; Schaff, Fielding, Westhoff, et al., 2000). The option sounded right for her, but there were still issues: she was breastfeeding to keep the baby quiet at night; she would need to discontinue breastfeeding for three nights while she took these medication; and, finally, how could we explain everything to her husband?

She was pretty sure he had guessed she was pregnant. While we brainstormed ways of getting around telling him she was having an abortion, I did her sonogram, baby on her lap again. The pregnancy was very early, and the sac was just visible. In fact, it looked a bit ragged to me, not the

well-defined circle it usually is. I mentioned the possibility to her that the pregnancy might not be viable; she looked elated at this idea. I suggested we wait one week to see whether or not the pregnancy developed properly, while she thought some more about her choice. Whatever her decision, I reassured her, I would be there to help her. She reiterated that she just could not have another baby now and tearfully left.

I knew this was hard for her. I could not help but think back to the first time I got pregnant and did not want to be. The year was 1970, I was 18, and abortion was illegal. I had gone to see a doctor who advertised pregnancy diagnosis in the student newspaper—I was terrified. He practiced on the south side of town, an area to which students rarely traveled. He was an elderly African-American man who was quite gentle with me and read the terror in my face when he gave me the news. He slipped me a note with a name and phone number on it. He said, "If you don't want to continue this pregnancy, call this number."

When I returned to my dorm room, I locked the door and, with shaking hands, dialed. A professional voice answered, someone's law office—I hung up, panicked. The name on the paper just said "Marilyn." How could this be? I paced and paced. What should I do? I talked myself into trying the phone number again. This time I asked for Marilyn. A woman picked up and said, "This is Marilyn." I stammered that a doctor gave me her phone number. She interrupted, "I understand. I need to meet you and give you some information. Write this down." Knowing what I know now about how difficult it is for people to remember things when they are stressed, I realize how smart her directive was. She instructed me to meet her on a corner near the campus library at a specific day and time. She asked me how she would recognize me and for my first name.

Over the next few days, I tried to go about my normal life. I had begun vomiting behind the cafeteria before I reported for work. I only told my boyfriend about my pregnancy. He was as shocked and scared as I was. The day I was to meet Marilyn, I felt so faint I wondered if I would make it. I didn't even know enough to understand that it was weakness from the nausea of pregnancy, combined with being scared to death. I got to the corner early and then wondered if I should worry about someone watching us.

Even though these events are now more than 30 years ago, their details remain crisp. "Marilyn" gave me a list of psychiatrists who would write a letter for me stating I was suicidal. I made the required appointments with two of them. One was very kind and gave me the note without charging me anything. The other was mean. Before giving me the letter, he asked me intrusive questions until I cried, leaving me feeling like I *should* have been suicidal. The hospital ward where I stayed overnight was in the back of the maternity floor. Some of the girls were having a "salting out" procedure and were crying in pain. The nurses would not come when we called, but talked among themselves just loudly enough for us to hear: "Sluts. They didn't cry when they were getting themselves knocked up."

The humiliation and degradation of that experience stays with me and strengthens my commitment to shape a humane experience for women who need abortion. I find that women try very hard to have babies at the right time, when they can do their best for them. Their decisions are rarely selfish, rarely easy, and never undertaken without a lot of thought. Like Rameesha, women find themselves pregnant despite their wishes or plans. Like her, many have the needs of other children to balance. Abortion is incredibly common; 45% of all women of reproductive age in the U.S. have had one (Henshaw, 1998). These statistics hit home when we began to offer medical abortions in our office. A significant

percentage of my first patients were staff members and their friends and relatives! This helped finally convince the staff as a whole of the importance of making the medical abortion service available in our family medicine clinic.

The stories of the women who come to me for medical abortion inspire me and sadden me. Often, they are facing a huge roadblock to their dreams to finish school, to get a first child into daycare, to earn enough for a home. They want to have a life where a child would be welcomed.

Rameesha came back that next week. She was feeling less nauseated. I hoped this was a sign that the pregnancy wasn't viable. She was more decided now—she did want the pill for an abortion if the pregnancy was growing. She would tell her husband that it was a miscarriage and that she could not breastfeed because of antibiotics and pain medication she had to take. I did the sonogram with trepidation. The result was not clear. The sac was larger but still ragged and with no yolk sac or fetal development. It could still be an early pregnancy or it could be a blighted ovum. Rameesha wanted this process moved forward and asked me to tell her husband it was a miscarriage. She dialed him for me, and I gave him our story: the pregnancy was not developing normally, and she needed some medication to help it come out. That would mean she could not breastfeed for three days. The relief in his voice surprised me. "She is not ready for another baby," he said. "This must be God's way of helping us. This is for the best."

I wondered later if I should have pressed her to tell him the real story from the beginning. I had suggested it, but she was not willing. In my years as a family doctor, I have often found myself promoting communication between family members. Now that I offer medical abortions, this has become an even bigger part of my practice. I've worked with mothers and teenage daughters, couples, and parents like Rameesha and her husband. Some allow me to call a "family meeting" at which I facilitate the process of their talking with each other. Others accept referrals to family therapists. Others insist on the confidentiality that our doctor-patient relationship provides them and decline to discuss the abortion with their family members.

I worried about Rameesha making it through the medical abortion process without her husband having some understanding of what was actually happening. What if he got scared about the bleeding and insisted they go to an emergency room? Of course, the doctors there would not be able to tell the difference between an induced abortion and a miscarriage. But they would probably recommend a D&C, a suction evacuation of her uterus, which she was trying to avoid by choosing a medical abortion. I explained all of this to her, as I do to all of my patients, and encouraged her to call me if she had any concerns as the process unfolded.

As often happens, the medical part of her medical abortion was the least complicated and easiest part. She inserted her misoprostol at home as planned. The cramping and bleeding became intense in about 4 hours, and the heavy bleeding lasted for about 4 hours. She later described it to me as not much more than a menstrual period—except that she bled lightly, on and off, for 12 days. Since many of my patients are working women who don't even miss a day of work after their medical abortions, I was not surprised.

Rameesha was very relieved when she returned for her follow-up appointment, and the sonogram confirmed that her uterus was empty. Like many patients, she had been worried that it hadn't worked, because I had prepared her to expect a more difficult experience. Since there is wide variation in how women react to this process, I prepare everyone for the worst. I tell them that the bleeding will be heavy and that they should call me if they soak through more than two maxi-pads, for 2 hours back-to-back. I tell them the cramps may be very painful

and give them prescriptions for strong painkillers, if they need it. I get calls from only about 1 in 30 patients related to pain or bleeding and have never needed to refer anyone to the hospital. My "failure rate," like the other practitioners in our network who also offer medical abortions, is the same as the rate in the most recently published studies—0.4%.

When my patients call, my usual approach is to listen to their concerns and recommend taking ibuprofen. Then I tell them I will call them back in another hour. By that time, the worst of the pain and bleeding has almost always subsided, and they are feeling better. Only once, during my treatments of 150 medical abortion patients, have I had to call a patient back a second time for prolonged pain—hardly a burden for me.

At the same time, the gratitude of these patients has been greater than that of any others I've worked with in medicine. These women are often feeling very down on themselves. The fact that my staff and I treat them with understanding and respect is almost transforming for them. As one patient expressed it, "Women beat themselves up enough when they need an abortion. We are the first to hand out the recriminations and feel ashamed of ourselves. Coming here, you all have helped me through a really hard time and helped me get past the "bad girl" stuff and move on to feel like a responsible woman. For that, I will be forever thankful."

I have been able to continue my involvement with Rameesha and her family. Like almost all of the women who come to me initially for a medical abortion, she has stayed on to be my family medicine patient. She no longer takes her son to the neighborhood pediatrician. With his frequent well-child checks, I have had the opportunity to follow up with her on many important issues: parenting, contraception, and becoming a comfortable community member.

Most of my medical abortion patients come from other family doctors in our network or in the community. Patients also find me on their own through the Web site of the National Abortion Federation. I keep flyers in my office about medical abortion and get into discussions with other patients who notice them. They, too, have been overwhelmingly supportive. Many say things like, "I'm glad to know my doctor is pro-choice." Or, "It's not for me, but I think it should be available and I'm glad you are brave enough to do it." If patients from our practice are unhappy to see that we are offering abortions, they have not made their feelings known, nor have we received any harassment from anti-choice protesters.

I thought that offering abortions in a family medicine setting would feel safe only in a place as diverse and tolerant as New York City. But I recently attended a national meeting where family physicians offering abortions in their practices met over lunch. Doctors from New Mexico, Arizona, Montana, rural California, Connecticut, and many other states all described the same experience: offering abortion helped their practices grow, not shrink! We all agreed that we felt incredibly rewarded by offering women choice about when to have children. My patients are endlessly thanking me with both hugs and personal stories of their efforts to live out their dreams—dreams of being a mother in the best way, at the best time, with the best partner, under the best circumstances that they can.

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