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Mapping the Landscapes of Abortion, Birth Control,  
and Power in the United States: Body Politics since  
the 1960s

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### Providing Comprehensive Care: Marissa Galloway Interview

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# Providing Comprehensive Care: Marissa Galloway Interview

Anne Légier

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## AUTHOR'S NOTE

L'entretien a été réalisé en septembre 2018/ The interview was conducted in September 2018

Anne Légier (AL): You provide reproductive health care in a conservative state. Can you tell me a little about that: your experience, what it means for you, what it means for the women you provide care for?

Marissa Galloway (MG): I think that the biggest thing that it means is that the options that women have and potentially the travel distance and barriers to seeking the services that they need are more so than in states or larger cities where there aren't those challenges. Each state in the US is very different in which political challenges they have dealt with and impacts of these legislative initiatives on health care and how it's provided, from the coverage issue, the health insurance coverage issue—I think that's one of the biggest challenges in many of the conservative states—because the Affordable Care Act<sup>1</sup> allowed for health exchanges to not include any abortion services in their plans and so, even if you have a private health insurance plan, there is no precedent that is being set by covering that and so many private plans don't include that as well.

AL: That's also true for birth control, right?

MG: For birth control, it is a little bit different because there was a mandate under the Affordable Care Act to cover contraceptive options as a part of preventive health care.

AL: But, wasn't there the Hobby Lobby (The US Supreme Court 2014) case...?

MG: Yes, there are the options for these different companies who have a religious foundation—they have to be private companies and show proof of that in different ways legally—and they can opt out of coverage but they do have to still offer women a

different plan that they can purchase that is external to their primary plan. The hard thing is that that's one more barrier, you know? Most people don't understand health insurance in this country, and you are already making it hard, and you are going to pay additional for something when you could also just walk in to a reproductive health clinic and get that without using your insurance for a low cost for many methods. So, women often don't really understand what they may be missing out on their plans and what they have to ask additional coverage for.

AL: Do you think there could also be a privacy issue: they don't want to talk about this to their insurance company?

MG: Absolutely, and it's probably not so much the insurance company but the Human Resources at their individual company. They would then essentially out themselves as somebody who is using contraception because they are asking for an additional plan to cover these methods. Because, usually, the Human Resources person who is within that company helps to connect the employees to plans. So, they are already connecting them to their primary plan but they would have to ask for additional coverage for that service.

AL: What about abortion coverage? Are there companies—I don't know anything about insurance—so are there companies that do cover abortion? And would that mean that you would have to sort of disclose to your employer that you are having one?

MG: No. So, for the private insurance plans that do cover it, the employer never sees what you are using it for.

AL: So, it's like if you have cancer?

MG: Exactly. So, whether you have a bill for knee surgery or for an abortion, the company never knows. You just pay your premiums and they know you are a person who has that insurance plan. But many private insurance plans don't have coverage for abortion care or they might have coverage in certain circumstances—and that's something that we struggle with on a regular basis and becomes a barrier for women even when they're terminating for a lethal fetal indication or for maternal health indications—often their insurance policy refuses coverage regardless of the indication and they're left with having to pay out of pocket.

AL: Even if it is life threatening?

MG: Yes. So, the insurance policies will have coverage for maternity care and so they will pay for your labor and delivery if you go further in pregnancy but they won't pay for termination and so women also struggle with where they can have their abortion care done too because, let's say their fetus has a lethal abnormality such as trisomy 18 (a genetic abnormality), if they opt to terminate that pregnancy early on—and this is a baby that would never survive outside—the company won't pay for it, and then they have to decide “well, do I have this in the hospital where it can cost upwards of \$10,000 out of pocket to have a termination or have it in a freestanding abortion clinic where it can be more like a couple thousand dollars?” So it also marginalizes their care even, regardless of the reason that they are choosing is based upon their coverage.

AL: In France it is very different because we don't have the clinic system, at least for abortion care. From what I see, the fact that abortion care is part of a global hospital practice, it's sort of lost in there which means it doesn't become a target... because hospitals provide abortion but it is not identifiable in any way: people come in and out and nobody knows what they are coming in for<sup>2</sup>.... I know that the idea of abortion clinics comes

from a feminist idea of a specific kind of care, but I wondered if you had any thoughts on this idea of also marginalizing the practice by reinforcing clinic versus hospital care...

MG: Well, it comes from the history of abortion in the US, of how this started. When abortion was illegal, in the states where they had more options to provide it, they often did it in these freestanding clinics and the only providers who knew how to do it were providers in these freestanding clinics. I shouldn't say "the only": there were many people in many settings who did, but the highest volume was often in these settings. And so then, once abortion became legal across the country, most ob-gyns had not had abortion training and now, how do you train a whole generation of providers and how do you suddenly get these services in the places that they weren't? So, there were these barriers that just naturally evolved to provider training, to accessibility, and these freestanding clinics often took over the role of providing these services because they could also do it in a more timely, less costly setting. Because the hospital overhead costs are so high you've got to pay either out of pocket or through private insurance, so abortion clinics can do just that: they can keep the cost contained and provide that one service. But, unfortunately, it still limits how many trainees are seeing abortion care because it is not in the hospitals where they are training and so they have to actually choose and go out and access this additional training which may not be as easy, and there is still stigma associated with that when you are the person who is saying "I want to go out and do that."

AL: I understand you are a professor... You teach in a hospital, right?

MG: I teach in many settings but primarily in hospitals and clinics.

AL: So, your medical students... do most of them just not have any training in termination or do they just do D&C<sup>3</sup> training for miscarriages?

MG: So, all medical students have these core rotations that they have to do and ob-gyn is one of them and their experience is usually split between inpatient labor and delivery and inpatient gynecology, and they do a little bit of clinic time as well so they can then opt—at least in our program—and each program is different—they can opt to have more of a family planning exposure and go to a freestanding clinic during their clinic time but that might be a couple dozen students for the whole year when you have got over a hundred. So most medical students are not actually going to the freestanding abortion clinics for any exposure and so they may, if they just happen to be on delivery when there is an induction termination that day, they may see that but that's not the reality of most abortion care in this country; and when they are on gynecology they might see some D&Cs for miscarriage management so that they at least see the procedure but there is still this lack of understanding that it is the same procedure regardless of the indication.

AL: Is that a concern for you? Are you worried about what the next generation of doctors—you are a pretty young doctor yourself—but the next generation of doctors is going to be able to do for women who need abortion care?

MG: Absolutely, and this is something that's been an ongoing conversation for a few decades in this country of how do we integrate this into our medical education training, how do we integrate it into our ob-gyn and family medicine residency training? And so each institution is doing things a little bit differently but it is one of the requirements through the Governing Board for accreditation of these residency programs that ob-gyn residency have to offer abortion training to their residents but that doesn't mean it is done in a way that makes it easy in many settings: there are places where in order to

get that—even though it is offered—the resident has to opt out of doing a gynecology rotation which then shifts that work on to their colleagues and then travel a couple hundred miles to stay in a place where there is a freestanding clinic and work there for a couple of weeks and leave their family behind and so there are barriers to getting that training even though places are supposed to offer it.

AL: I also wanted to discuss one of your fields of interest, pregnancy intendedness: can you tell me how you think it's an issue in the United States and do you think it has something to do with the sex education or the lack of sex education provided in American schools? I know that it is very different from state to state but from a French perspective, again, it is very surprising what some states consider to be sex education...

MG: Yes there isn't much, unfortunately...There isn't much sex education. Sex education is definitely a barrier that starts early on for American citizens in general, each school does things differently, each school district, each state. There has been a big push because of national policy to really focus on this abstinence-only education but without giving adolescents any information on how their body works and how you could prevent a pregnancy or a sexually transmitted infection, how do you engage in a consent process with another partner, or not have a power differential in sexual encounters, there is so much that's missing... And, as an ob-gyn, when I see young women who are often coming in for a first exam and we are talking about engaging in sex and use of contraception, they have no understanding of their anatomy when they go through these basic state-sponsored sexual education programs. They don't understand where their cervix is or that it's connected to their uterus. We really start these exams pulling out a pelvic model and just explaining to them their anatomy, which is something you would think would be part of their health education very early on and so you have to do that before you get even to the part about how sex functions and how pregnancy occurs, and how birth control can prevent a pregnancy if you don't want it. So, it is hard as a provider. And that's obviously variable, most doctors don't have a half hour to spend giving you some baseline education that you should've already received.

AL: There must be a lot of young women who never see a doctor before they actually get pregnant...

MG: Right. We see a significant number of young women whose first encounter with a reproductive health provider is with their abortion care services. So, they are already having sex; many of them don't understand timing of sex or when you can get pregnant—or their cycles—and then, unfortunately, are trying to walk themselves backwards a bit with this knowledge. That definitely affects pregnancy intention in this country: even though teen pregnancy numbers are declining, it's not because of abstinence-only education. It's been due to a push to get younger adolescents on to birth control before initiation of sex and that's not been within the schools, it's been a push from public health components and family planning groups to make these methods more acceptable to younger adolescents.

AL: What types of contraceptives? I remember talking to an American ob-gyn who talked about IUD's for teenagers?

MG: Yes

AL: Because in France they don't do that<sup>5</sup>...

MG: Yes, so the American Pediatric Association and the American College of Ob-Gyns both put up practice guidelines to support use of IUDs and also contraceptive implants

as first line contraception for adolescents just because we know that the other methods are very user-dependent. Adolescents have chaotic lives and remembering to take a pill every day or putting in a ring once a month is hard for them when they are just trying to figure out how to navigate life.

AL: So, these are very effective methods?

MG: Yes, so we know that these long-acting methods you can use for many years: you put them in and forget about them and they can get these adolescents to a point when they can decide later on if they want to get pregnant or if they are not happy with that method too. So, there is definitely a push. But we see a lot of unintended pregnancies especially in unmarried couples and so the abstinence-only, wait-till-you-are-married thing does not seem to be working out so well in this country.

AL: Do you see a link with some religious cultures?

MG: Absolutely.

AL: Do you see more teenagers who are actually from a religiously conservative background?

MG: It's really a mix. You could pick any religious group and say "well, it's all this" or "it's not this" but in the end all of the teenagers are teenagers and they all have hormones regardless of the religious teaching and some will get pushed into early marriages or some of them show up for an abortion and then they are right back preaching the anti-abortion strategies.

AL: That must be tough, for the provider I mean.

MG: Yes, awful. That's definitely an issue. But the other big issue too, outside of the social implications of it, is that we have a country that does not really prioritize preventive health care. We have a huge chronic illness problem in this country: obesity, a lot of substance abuse issues... All these things increase the risk of adverse pregnancy outcomes and so when pregnancies aren't planned and they happen at a time when a woman's disease is not controlled or when she's having issues with substance abuse or you put the social aspect of an abusive relationship into this, these are all things that affect both maternal and fetal outcomes. That's where the issue of unintended pregnancy is even more detrimental not only to this generation but to the future one too.

AL: Costly, also?

MG: Yes. A lot of these pregnancies are funded on public insurance and so women who don't have insurance until they get pregnant have this window of coverage during their pregnancy, and insurance will pay for their delivery and the second they deliver they are cut off again. There is no way to continue to optimize their health issues beyond that without insurance.

AL: Can you tell me how you decided to become a reproductive care physician? Since it is not mainstream in a way—as you explained earlier—what made you want to do that?

MG: So, I trained in a residency program in a place that wasn't very restrictive but, regardless of that, I saw that most of the general ob-gyns who I worked with and saw a large number of providers did not receive training in abortion care in their residency programs, and so I just found it concerning that, as a generalist provider who is supposed to be able to take care of women throughout their reproductive lives, they would tell women "well, I'll take care of you if you get pregnant, I'll take care of you if

you have a miscarriage, I'll take care of you if you need a C-section, but if you decide to terminate the pregnancy, I'll have to send you out to this freestanding clinic to see someone that you don't know for a procedure that takes 5 minutes and is the exact same procedure that I could do for you if you were having a miscarriage." And so it just seems so bizarre to me: if I want to be able to provide comprehensive care to my patients, this is just one of the many things that women need throughout their reproductive lives and I want to be able to safely provide it and not tell women and add to the stigma around the issue by saying "I can't take care of you in this setting."

AL: It's an argument that could be made for primary care physicians too. Do you know of primary care physicians that do provide abortion care as part of their general practice?

MG: So, within primary care there are different tracks to get there and so many primary care physicians do internal medicine residency and in that residency training program they don't really get exposure to obstetrics but there are family practice residency programs, and family practice doctors do obstetrical rotations as part of their training, and some of them can actually go on and do additional training and provide obstetrics as part of their practice. And so, for them, there are many who do provide abortion care too because they feel more comfortable with the obstetrical part of it but, unfortunately, the exposure to abortion in family practice training programs is even more limited than in ob-gyn training programs and so the number of providers from that background is pretty limited.

AL: Do you think that the general fear of being identified as a provider also hinders people from doing something they would want to do as part of a comprehensive practice but don't feel comfortable enough to do?

MG: Absolutely. Carole Joffe has written about that. So, there is definitely a provider stigma that's associated with it and also other barriers too because if you don't really get exposed during your training program... then you need to get a partner later on, it's important, and there are many practice groups where, even if I came in and said "I want to provide this and they'll say well, if you get a job with us we don't want you providing this because we don't want to be known as a group that provides that... then you've got privileges to do deliveries in a hospital and the hospital says well, you can't do it here. There are some layers to it that become barriers to providing if you want to.

AL: You have mentioned it already but would you say that being a provider is difficult on a day-to-day basis? Would you also say it is rewarding? Is it both?

MG: Well, it's one part of my job, you know, I do a lot of things at my job, including providing general ob-gyn care and delivering babies in pregnancies that women want to go forward with and so, again, I think being able to provide comprehensive care and full-spectrum care is what's important and rewarding to me. Patients who I care for, who have terminations, are so thankful that they can go forward with their lives and so fearful about it because there is so much stigma and misinformation out there, and so for me to provide them with a safe experience that's just like any other health care is often shocking to them: they'll come in and say "oh I'm so surprised that you weren't mean to me." Well, just because you are making a health care decision? Like, I would be mean to you if you were coming in and having... you know, knee surgery or whatever? There is that belief that it is somewhat different and should lead to lesser care [which] is hard. So, being able to provide good care and safe care is definitely rewarding and seeing them being able to leave with the birth control method of their choice and go on with their lives and plan for a pregnancy when it fits is very rewarding.

AL: That's interesting because there are a lot of providers who seem to—from the outside it seems like a lot of providers, because of the demand for it and the small number of providers—specialize and end up doing only that even if it is not necessarily what they would have wanted in the beginning...

MG: I would say that most providers actually have a mix. There are some who that's all that they do but the norm is more that you work in a hospital too or you work for a practice, and then you either provide it as part of your practice or some will go and work a day or a half day a month at a freestanding clinic and provide services there as well. So, I feel more and more it's a mix. Historically, though, especially when it was illegal, and people were training to fill these freestanding-clinic models, that would be all the provider did. But that's also why the abortion provider term is not really the same as it was 30 years ago.

AL: So what's the term you would use for yourself?

MG: I'm an ob-gyn. I don't call myself a *C-sectionist* or, you know, a *hysterectomist*.... It's a procedure and it goes along with the comprehensive care I want to be able to provide to my patients.

AL: That's very interesting. I had never heard it phrased that way. I also wanted to ask you about the political climate. We mentioned the fact that you work in a conservative state but there is a global conservative climate, there are discussions around the Supreme Court, the composition of the Supreme Court... So, is that something you worry about?

MG: Unfortunately, I have very little control over the Supreme Court, personally. And so while it is a concern, there are regular every day challenges just getting care for my individual patients that are more concerning to me. You know, I hope that people realize that when they don't vote and when they might make a protest vote, they get many decades of challenges because of it, and so, I don't foresee the road ahead being easy from a national perspective. But I just hope that, in my day-to-day work, I can continue to take care of the patients that I see and help them overcome the barriers that are put in place and have conversations with people who lead political agendas to make them understand that the most effective way of preventing an unintended pregnancy and an abortion is through comprehensive contraceptive coverage and education, and supporting women in their roles in this country. This conservative agenda is essentially just trying to keep women in their place and pregnant and not at work and leads to all these adverse outcomes that we see. So, I think most people—when you start really talking about how healthy pregnancies are planned pregnancies and how that occurs in women who have some say in their lives, that are happier in their lives, that have a relationship with somebody who supports them—you kind of get at the core of what everybody wants. And so taking away the labels that people put on it, and stop walking in and saying “I want to talk about abortion policy” or “Let's talk about how we can support girls in this country.” It's just the conversation we all want to have but then people get so politicized over these labels that it's hard to get to common [ground].

AL: I think I read recently that people identify with labels that they actually don't really belong to. Meaning if you ask them specific questions, they actually think that they are pro-life or pro-choice but are not really what they think they are...

MG: Yes.

AL: Because it's more complex than just labels...

MG: Yes. And that's medicine. There's a lot of [grey area] to it.

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## NOTES

1. The Patient Protection and Affordable Care Act (PPACA), often shortened to the Affordable Care Act (ACA) and usually referred to as *Obamacare* is a 2010 federal law making health coverage easier to navigate and to afford. Patients can purchase health insurance that comply with the PPACA from government-regulated health insurance marketplaces, also called “health exchanges.” The PPACA also expanded the Medicaid program to cover more people with low incomes.
2. In France, abortions can in fact also be performed in private clinics, but these facilities are not identified as being “abortion clinics” as they provide comprehensive health care.
3. D&C stands for *Dilation and Curettage*, a medical procedure where the cervix is dilated in order to remove uterine tissue with a small instrument called a curette. D&Cs are often used to remove retained tissue after a miscarriage. They are also commonly used to terminate a pregnancy.
4. IUD stands for Intra Uterine Device, a common contraceptive method.
5. While IUDs are the second most common contraceptive method in France, they are almost exclusively used by women who have already had children. As of 2010, only 1% of French women under 25 were using an IUD (Moreau et al. 2014).

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## ABSTRACTS

Marissa Galloway is an ob-gyn who practices in a conservative state. At her request, we are not using her real name to protect her anonymity. Even though abortion is one of the safest and most common medical procedures in the United States, abortion providers hold a very unique position in the landscape of American healthcare. Anti-abortion violence has threatened and marginalized the procedure and those who make it possible (Cohen and Connon 2015; National Abortion Federation 2018). Since 1993, eleven people—including four doctors—have been killed by anti-abortion extremists. Other attacks on clinics and reproductive health care providers have included, sometimes on a daily basis, death threats, blockades, harassment of family and neighbors, but also bombing and arson of offices, battery, kidnapping and attempted murder. In this interview, Marissa Galloway explains, among other things, the barriers American women face in trying to access reproductive health care as well as her belief that abortion is an integral part of comprehensive obstetrical care.

Marissa Galloway est gynécologue-obstétricienne dans une région conservatrice des États-Unis. À sa demande et afin de protéger son identité, nous utilisons ici un pseudonyme. Elle fait en effet partie d'une petite minorité de médecins qui intègrent l'avortement à leur pratique médicale. Même si l'avortement est l'une des interventions médicales les plus sûres et les plus courantes du pays, les médecins pratiquant des avortements sont relégués aux marges du système de santé américain et menacés par la violence des groupes anti-avortement (Cohen et Connon 2015; National Abortion Federation 2018). Depuis 1993, onze personnes, y compris trois médecins, ont ainsi été assassinées par des militants opposés à l'avortement. On dénombre également des enlèvements et des tentatives de meurtre ainsi que des attentats à la bombe et des incendies volontaires à l'encontre de cliniques. Le harcèlement et les menaces sont monnaie courante. Dans cet entretien, Marissa Galloway évoque, entre autres, les obstacles rencontrés par les Américaines en matière d'accès à la contraception et à l'avortement ainsi que la place de l'avortement dans sa pratique médicale. Galloway resitue l'IVG comme étant au cœur et non à la marge de la gynécologie américaine.

## INDEX

**Mots-clés:** grossesse, avortement, IVG, contraception, éducation sexuelle, abstinence, santé, médecin, gynécologue-obstétricien, femmes

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