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Abortion Providers and the New Regulatory Regime: The Impact of Extreme Reproductive Governance on Abortion Care in the United States

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AUTHOR'S NOTE

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- 1 In a useful contribution to social science work on reproduction, the anthropologists Lynn Morgan and Elizabeth Roberts (2013) have elaborated the concept of *reproductive governance*: they have described this as “the mechanisms through which different historical configurations of actors—such as state, religious and international financial institutions, NGOs, and social movements—use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviors and population practices.” In this article, I suggest that the regulation of abortion in the United States, particularly since the consequential midterm elections of 2010, can be viewed as an extreme version of such reproductive governance: this governance manifests primarily through the “legislative controls” identified by Morgan and Robert. These controls, in turn, are reinforced by powerful religious forces and social movements which commit large resources to electing politicians firmly opposed to abortion. Relatedly, another concept that guides this paper is that of “abortion exceptionalism,” described by the legal scholar Caitlin Borgmann (2014) as “a term that has been used to describe the tendency of legislatures and courts to subject abortion to unique, and uniquely burdensome, rules.” I contend that the elements

of reproductive governance in play in the abortion issue, which have contributed to the resulting “abortion exceptionalism” prevalent in many states’ regulation of the procedure, are both reflective of, and contribute to the significant cultural stigmatization of abortion in the U.S. (Norris *et.al.* 2011). This stigma, which affects abortion patients and abortion providers alike, makes resistance against a harsh regulatory regime even more difficult.

- 2 The particular focus of this paper is a discussion of how abortion providers located in highly regulated “red” states are affected by this challenging regulatory climate. Though not the focus of this paper, others have documented the hardships on patients imposed by recent restrictions which have made accessing abortion care more difficult (Grossman *et. al.* 2014; Jerman *et. al.* 2017).

Background: The regulation of abortion since *Roe v Wade*.

- 3 To offer briefly some historical background on the regulation of abortion, Congressional efforts in this realm started immediately after the *Roe v Wade* decision in 1973 which legalized the procedure. In the same year, Congress passed the Church amendment (named after its chief sponsor, Frank Church) which stipulates that hospitals or individuals’ receipt of federal funds in various health programs will not require them to participate in abortion and sterilization procedures, if they object based on moral or religious convictions. The measure also forbids hospitals in these programs to make willingness or unwillingness to perform these procedures a condition of employment (C. Marshall 2013). The Coats amendment (named for its chief sponsor Daniel Coats) passed in 1996, and similarly states that no federal funding will be withheld from any hospital that refuses to engage in abortion training; this amendment, a prime example of the above-mentioned “abortion exceptionalism” that typifies legislative oversight of this procedure, was unprecedented in that it nullified a ruling of the American Council of Graduate Medical Education and CREOG (the Committee on Residency Education in Obstetrics and Gynecology) which had recently put in place a requirement that residencies in this field include routine abortion training, with an allowance for an opt-out for residents with moral or religious objections to abortion (Foster *et.al.* 2003). I could locate no other cases of Congressional interference in the setting of standards by medical educational bodies.
- 4 The Supreme Court, in a series of decisions starting shortly after *Roe*, gradually permitted more and more limitations on abortion provision at both the state and federal level. Among the first of these was the *Harris v McCrae* decision in 1976, upholding the Hyde amendment (named after the late Congressman, Henry Hyde) which forbade the use of Medicaid funding for abortion, except in very limited circumstances, a policy which stands to this day. Subsequent Court rulings upheld such regulations as parental notification and consent requirements, and waiting periods before a woman can receive an abortion (which currently extends to 72 hours in some states). The 2007 *Gonzales v Carhart* case marked the first time that the Court expressly banned a particular medical technique, in this case a fairly rare procedure used in later abortions that doctors felt to be safer in certain situations. *Gonzales v Carhart* is also notable for the fact that it marked

the first time in abortion jurisprudence that the Court did not require an exception for women's health (Luker and Murray 2015).

- 5 Most regulation of abortion however, takes place at the state level. These restrictions, designed specifically for abortion facilities, have earned a special name in legal circles: TRAP laws, or Targeted Regulations of Abortion Providers (Center for Reproductive Rights 2015). All told, there have been over 1,200 restrictions passed by state legislatures since *Roe*. The number of these increased dramatically after the 2010 midterm elections (widely seen as a backlash to Barack Obama's election two years earlier), which brought a significant increase in Republican governorships and control of state legislatures—and strong pressure for favorable legislation from anti-abortion groups which had worked assiduously for Republicans' elections. Republicans made similar gains in the 2014 election, again seen as a backlash to Obama's re-election. Nearly a quarter of all state-level restrictions (over 300) have been passed since 2011. The election of Donald Trump to the presidency in 2016 was accompanied by even more victories for Republicans in state legislatures, and as of this writing in fall 2017, Republicans control 33 governorships and control 69 state legislative bodies, and additional abortion restrictions continue to be introduced at a rapid pace (Phillips 2016).
- 6 In addition to Republican electoral gains at the state levels, there have been two additional recent events of note which have also increased pressures for additional restrictions on abortion providers. The first is the explosive case of Kermit Gosnell, a "rogue abortion provider" (Joffe, 2010) in Philadelphia, who was arrested in 2010 for the negligent care (including some deaths) of patients and for the murder of several newborns who were born alive after failed abortions (Hurdle and Gabriel 2013.) Gosnell's case was further inflammatory because of the unsanitary conditions of his clinic and of his illegal use of untrained staff. Though many complaints had been lodged against him, including by other Pennsylvania abortion providers, inexplicably the state Department of Health had for years not responded to these complaints. Both in Pennsylvania and elsewhere, the Gosnell affair was invoked as justification for stringent new regulations. In Pennsylvania, for example, almost immediately after the Gosnell case came to light, the legislature passed a law requiring that all abortion clinics become licensed as Ambulatory Surgical Facilities (an onerous and expensive requirement, to be explained further, below).
- 7 The release in July 2015 of undercover videos made by an anti-abortion group, the Center for Medical Progress, which purported to show clinic personnel "selling" fetal tissues to researchers for profit was the second event that spurred additional intense scrutiny on abortion clinics. These videos, which were highly edited and misleading, and which have resulted in ongoing litigation against the perpetrators, including felony charges (Hamilton 2017), nonetheless resulted in numerous investigations of abortion clinics by both state and federal agencies. Though the primary targets of the video-makers were Planned Parenthood clinics which performed abortions, some independent clinics were also caught in this sting operation. In response to these videos, Republicans in Congress established a "Select Committee on Infant Lives" which began an investigation of the practices of abortion providers, whether implicated in the videos or not, who provided later (post 20-week) abortions. This Committee was roundly denounced as a "witch hunt" by many in the press and Democrats in Congress (*Washington Post* Editorial Board 2016).

TRAP Laws

- 8 The restrictions that have been introduced since the 2010 election, generally speaking, represent a switch in emphasis from the historic pattern of regulating the behaviors of individual women seeking abortions e.g. “the demand” side, to those providing abortion—the “supply side” (Joyce 2011). That is, while earlier abortion restrictions focused on such matters as waiting periods, and parental notification and consent provisions, more recently the emphasis has shifted to restrictions bearing on the physical and staffing characteristics of abortion providing facilities. Many of these restrictions have been put forward as model legislation by a leading anti-abortion legal group, Americans United for Life (2016). In terms of clinics’ ability to comply with the new regulatory regime, the most consequential of these so-called “TRAP” laws have been the above-mentioned Ambulatory Surgical Facilities (also known as Ambulatory Surgery Center (ASC)) requirements, and physician admitting privilege ones. The former stipulate that abortion facilities must conform to the physical specifications of small hospitals, with respect to such issues as air flows, hallway widths, janitor locker space, and so on, as well as to hospital-level sterility practices—and the physical requirements that can cost well over one million dollars, as was noted by the Majority in the recent Supreme Court case *Whole Woman’s Health v Hellerstedt* (*Whole Woman’s Health*), a landmark case which I shall shortly discuss further. The latter, which requires doctors providing abortions to have admitting privileges at local hospitals, has been extremely difficult for many clinics to implement, both because of the local political climate leading hospitals to refuse such applications, as has been widely reported in states such as Texas, Mississippi and Alabama, as well as the fact that routine abortion care is so safe that abortion providers are typically unable to meet the requisite number of hospital admissions per year that many institutions require. As the director of the only clinic in North Dakota, threatened with an admitting privileges restriction, said to a journalist, “I would never employ a doctor who had to admit ten patients a year. That would mean they were a terrible doctor.” She went on to point out that her clinic had only one hospital admission in the past ten years (Marty 2013).
- 9 Numerous medical groups, including the American College of Obstetricians and Gynecologists (2014) have asserted that both the ASC and the admitting privileges requirements do not have an impact on patient safety, but have as their sole purpose the closing of clinics. Indeed, the safety record of legal abortion in the U.S. since the *Roe v Wade* decision in 1973 is very impressive, with medical researchers demonstrating that the death rate from legal abortion is 0.6 per 100,000 procedures, meaning that a woman is about fourteen times more likely to die in childbirth than from abortion (Raymond and Grimes 2012). Moreover, observers have pointed out that in a number of states requiring ASC standards for abortion clinics, other outpatient facilities offering comparable levels of procedural complexity—for example, those offering vasectomies, sigmoidoscopies and minor neck and throat surgeries—do not have such a requirement. Similarly, the Majority in the Texas case, *Whole Woman’s Health*, noted (*Whole Woman’s Health* 2016, p. 30) that colonoscopies, which are not subject to ASC requirements, have a mortality rate ten times higher than abortion, while outpatient liposuction, also not subject to such regulation, has twenty-eight times the mortality rate of abortion.
- 10 Beyond passing new abortion restrictions, anti-abortion politicians in various places have additionally brought pressure on state bureaucracies to more frequently inspect abortion

clinics to ascertain that these facilities were complying with both existing and new laws. This heightened scrutiny of abortion clinics has had significant consequences, obviously, for the clinics themselves, but also for state health departments, which are the main (though not sole) agencies charged with monitoring these facilities. Therefore, in this article I also note the dilemma this situation can impose for health department employees, when the political imperatives of their superiors clash with the inspectors' integrity as public health professionals. In short, this is a story of what happens when health care regulation becomes inextricably bound up with the most divisive issue in American politics. As of 2016, some 162 abortion clinics stopped operating, in large part because of an inability to meet the various "TRAP" regulations imposed by state legislators (Deprez 2016).

Recent Supreme Court developments

- 11 The landmark Supreme Court case, *Whole Woman's Health*, handed down in June 2016, marked an important development in the fate of abortion provision in the United States. The case, brought by a Texas abortion provider, challenged the two restrictions mentioned above, ASC requirements and admitting privileges. In a 5-3 decision, the Majority ruled in favor of the plaintiff, stating, "Both the admitting privileges and the surgical-center requirements place a substantial obstacle in the path of women seeking a pre-viability abortion, constitute an undue burden on abortion access, and thus violate the Constitution" (*Whole Woman's Health* 2016, p. 3). Had the plaintiff not prevailed, the number of abortion clinics in Texas would have gone from 40 to about 10. (However, a number of Texas clinics which had closed have not been able to re-open, for logistical reasons, in the aftermath of this decision and as of fall 2017, there are some 21 clinics in operation.
- 12 Encouraging as this case has been for abortion providers and the larger prochoice movement, the decision hardly ends the struggle over restrictions and "abortion exceptionalism," or indeed the future of legal abortion more generally in the United States. Given the 2016 election of Donald Trump to the presidency, which occurred several months after *Whole Women's Health* was announced, and his vow to nominate only "prolife" Supreme Court Justices, the fate of *Roe v. Wade* itself is unclear. (The appointment of Neil Gorsuch to the Supreme Court, early in the Trump presidency, brings another vote to the Court who is widely expected to favor the overturn of *Roe*). Some states, in the wake of *Whole Woman's Health*, have dropped attempts to impose ASC or hospital admitting privileges, but others have not, and these cases will have to be litigated. As the legal scholar David Cohen has pointed out, while this case may seal the fate of certain restrictions claiming to improve women's health, other restrictions remain and new ones will continue to be introduced. Cohen particularly points to the likelihood of more restrictions pertaining to "the dignity of the fetus," such as a law that the Texas legislature passed, immediately after the decision, which required that all aborted fetuses be given burials or cremation (Cohen 2016). At the time of this writing, this law remains in litigation. Beyond the emotional difficulties such a law might bring to some abortion patients, representatives of the funeral industry in Texas estimated that such a measure could add nearly \$1,000 to the cost of an abortion (Goodwyn 2016).
- 13 The harsh regulatory climate in the years immediately preceding the *Whole Woman's Health* decision and continuing into the present have taken a considerable toll on the

work force in abortion provision. As noted, over 160 clinics have had to close, many because of an inability to comply with restrictions. Of those facilities that managed to stay open in highly regulated, often politically hostile states, this feat has come at the cost of a huge expense of money and time and a struggle to sustain providers' commitment to long established principles of quality "woman-centered" abortion care. To be clear, none of the abortion providers interviewed for this study believed that their facilities should be free from state oversight. In simplest terms, this workforce wished to have their facilities regulated in a manner comparable to that governing other outpatient health care services, and not, as one clinic director put it, "to have regulatory tools used as a weapon against us."

Methods

- 14 Data from this study are drawn from in-depth interviews with individuals and small groups of abortion workers who work in independent (as opposed to Planned Parenthood) clinics in states that have a high degree of regulation. The decision was made to exclude Planned Parenthood clinics because clinics belonging to the Federation are more apt to have their policies set by a national office staff, while the independent clinics are freer to adjust their own practices to evolving political situations. All of the clinics contacted for this study are members of the National Abortion Federation (NAF), the leading professional organization of the abortion providing field. NAF membership implies that the clinics in this study were vetted by a visiting team of clinicians and were found to be in compliance with the standards of care set by that organization.
- 15 These interviews, which altogether involved some 50 individuals from nine states, were conducted both in person and by phone. The interviewees worked primarily in clinics in the South and Midwest, though staff members from several clinics in one Northeastern state were also included. I also conducted focus groups for three successive years (2014-2016) at an annual meeting of abortion providers from independent clinics. "Abortion provider" as it is used in this article does not refer to clinicians who actually perform the abortion procedure, but rather to those who are directors or managers of clinics and those who work in various senior staff positions. As the staff positions in independent abortion clinics are not uniform, often varying by size—in some cases, e.g. the director of a clinic may also be head of counseling or a manager may also work directly in patient care—my criterion for choosing informants was to select those who had some degree of supervisory authority over other staff. As the abortion providing community is very small (almost 90% of U.S. counties are without an abortion providing facility), especially in the highly regulated "red" states, it was not difficult to identify clinics whose staff who were most appropriate for this study.
- 16 In order to protect confidentiality, particularly in light of the security concerns of those in this field, I use no names of individuals or of clinics, except when these are identified in the press. Instead of the names of states in which clinics are located, I identify clinics by the region of the country, except when I quote from published material. I conducted data analysis in an inductive manner, first reading through the interview and focus group transcripts line by line to develop a list of themes, and then developing detailed coding schemes (Lofland *et. al.* 2005). This research was approved by the Institutional Review Board at the University of California San Francisco.

The Impact of Restrictions

1: Money and Time

- 17 Most fundamentally, complying with restrictions can impose enormous financial costs on clinics (clinics already have substantial extra costs—particularly in the area of security—that most other health care facilities do not (Deprez 2016)). This financial burden of ASC requirements was made explicitly in the Majority decision in *Whole Woman’s Health* which cited costs of over one million dollars as not uncommon to upgrade an existing clinic to an ASC (2016, p. 7). Obviously, not all clinics under such a mandate are able to meet this expense. The difficulty in paying for the transition to an ASC has been compounded because the increase in such restrictions has coincided with a sharp decline in the number of abortion patients for the same period (Guttmacher Institute, 2017), thus producing lowered revenues. In short, many abortion-providing facilities, before the imposition of ASC guidelines, already existed in a financially precarious situation.
- 18 But transforming a freestanding clinic into an ASC is costly beyond the funds involved, and involves a substantial expenditure of staff time. When a state legislature votes such a restriction, typically clinics are initially given a quite short time period to comply. Clinic staff persons therefore are suddenly compelled to spend a vast amount of time in political lobbying, both for extra time to comply, and to attempt to negotiate less stringent requirements. This lobbying of course takes them away from the everyday world of staffing a clinic. One director of a Midwest clinic told me she literally spent three months at the state capitol (several hours away from her clinic) as head of a state coalition attempting to stop, or at least modify the very harsh proposed restrictions under discussion by the legislature; she thus was forced to leave the running of the clinic to her subordinates. But at least lobbying is something usually at least one staff member knows how to do. The ASC regulation also abruptly thrusts clinic staff into a world of arcane details about widening existing corridors and developing measures of hallway airflow and so on—issues about which they have little prior knowledge.
- 19 A clinic owner in a Midwestern state showed me photos of a set of sinks—too high for her and most of her employees to reach—that cost \$25,000. These sinks were demanded by the licensing agency in her states. As she said to me,
- “But it was not only the cost of the sinks...each sink took three days to install, when we could not see patients. The walls had to be reinforced to hold them up and then re-wallpapered. This whole thing was just one example of what a huge waste of money (the newly imposed licensing requirements were)... Our old sinks worked just fine.”
- 20 One clinic visited for this study was subjected to an ASC requirement after the state legislature voted to impose such a regulation in response to the Gosnell scandal. The clinic spent thousands of dollars in obtaining outside legal and architectural consultation, and senior staff spent numerous hours in meetings with other abortion providers in the state, attempting to come up with a coordinated response to the new rule. One of the major tasks facing this particular clinic was to install a new HVAC (Heat, Ventilation and Air Conditioning) system. The requirements for this unit were so specific that the new system had to be built by a company halfway across the country and installed by crane, disrupting several blocks of traffic in the surrounding urban area. The clinic was forced to replace all the ceilings and floors in the procedure rooms to conform to the requirements

of a hospital operating room. After showing me this the new HVAC system, which truly resembled a Rube Goldberg contraption, the clinic director turned to me and said ruefully :

“and if you think about it, knowing what we know about abortion safety, our infection rates are not going to go down because of a change into the air flow, or the changes we made to the ceilings.”

- 21 This particular clinic, in short, spent hundreds of thousands of dollars for structural changes to their physical plant, changes that none of the staff felt in any way contributed to patient safety. And these expenditures for physical upgrades inevitably jeopardized other clinic functions. “We spent every cent we had [meeting ASC requirements] in order to survive,” the clinic director told me sadly, and went on to recount how the clinic had to eliminate their practice of administering free STD (sexually transmitted disease) tests to patients. However, a rare positive note in this clinic’s ASC saga occurred when staff encountered a woman who ran her own construction company. As one staff member related, the woman in question said :

“20 years ago I had an abortion at your clinic...when I left, I said, ‘somehow this will come back around’, and here we are...I would like to do as much as possible to help you.”

- 22 This company owner went on to devote a fair amount of free labor and construction material, a gesture that greatly lifted staff morale.

The Impact of Restrictions

2: Health departments and Disruptive Inspections

- 23 Inspections of abortion clinics have become inextricably embroiled in abortion politics. As one clinic director put it, “health department inspections are the anti-abortion’s movement latest tool of harassment.” The states of Virginia and Ohio serve as illustrative examples of the politicization of health departments with respect to abortion. The Virginia case moreover reveals the crucial role played by elections in changing the regulatory climate facing clinics. In Virginia, a Republican governor and a Republican-dominated state legislature passed legislation in 2011 mandating all of Virginia’s clinics conform to ASC standards, a move that threatened to close nearly all of the state’s clinics. The ensuing battle between the state’s then Attorney General—a religious right stalwart and a fervent opponent of abortion—and the state Board of Health over how to interpret and implement these regulations ultimately led to the resignation of the state’s Health Commissioner. In her resignation statement, she cited “an environment in which my ability to fulfill my duties is compromised and in good faith I can no longer serve in my role.” (Vozzella 2012).
- 24 The issue of abortion regulation played a key role in Virginia’s 2013 gubernatorial election, which saw a Democrat win over the above-mentioned Attorney General, who had threatened legal sanctions against those members of the State Board of Health who questioned such measures (*Washington Post* 2012). The newly elected Democratic governor put the ASC regulation on hold; moreover, at the governor’s direction, the state health department completed an exhaustive two year study of all 18 of the state’s remaining clinics—and as the *Washington Post* put it, “No evidence was found of violations that resulted in harm to patients at any of the state’s clinics, which perform an estimated

25,000 first-trimester abortions annually”; the *Post* went on to label the argument that the ASC requirement was needed for “safety” was “transparent nonsense” (*Washington Post* 2015). In September 2015, the Virginia Board of Health, dominated by appointees of the recently elected governor, voted to rescind the ASC and admitting privilege requirements for existing clinics, though future clinics will have to comply with some portions of the ASC code.

- 25 The state of Ohio has had for some time an especially hostile political culture with respect to abortion, perhaps best symbolized by the state legislature several years ago summoning a fetus to “testify” (via ultrasound technology) before that body (A. Marshall 2011). In particular, there has long been overt tension between the leadership of the state’s Health Department and the abortion providing community. This tension increased after the election in 2010 of a strongly anti-abortion governor with presidential ambitions; his appointments to high positions in the health department and the state medical board were of individuals without medical backgrounds but with long histories in the anti-abortion movement (Thompson-DeVeaux 2015). The pro-choice group NARAL sued in 2015 to obtain records of phone calls between anti-abortion groups and the state Department of Health, records which confirmed the collusion between these two groups (Ludlow 2015). Nine of the state’s seventeen abortion clinics have closed since 2010 due to various restrictions put in place by a conservative state legislature and signed by the governor, and several others are at risk of closing as of this writing.
- 26 Similar to the above examples, numerous clinics in this study reported intensified inspections from state and local health department, as well as other agencies, after 2010. These inspections were a major source of stress for clinic staff. To be sure, some portion of clinic inspections was regularly scheduled, as part of a state’s mandate to inspect all licensed health care facilities. However, some inspections, typically unannounced, were for the purpose of seeing if clinics were in compliance with recently passed ASC regulations. In other instances, the increase in inspections was a response to larger political events in abortion politics; for example, after the summer 2015 release of the misleading sting videos about alleged sales of fetal tissue in Planned Parenthood clinics, one clinic director (not affiliated with Planned Parenthood) responded to a knock on her door one morning to find agents sent by the state’s Attorney General who were there to investigate if the clinic “was selling baby parts.” Notably, some portion of the unannounced inspections recounted by clinic staff was triggered by often anonymous complaints, typically from anti-abortion groups such as Operation Rescue. One clinic director told me of an inspection that was prompted by a complaint left on Facebook by abortion opponents.
- 27 Some changes in the number and tone of inspections, providers reported, were in response to political events at the local level, for example, to meet the political ambitions of a governor or state legislator. A staff person at a Midwestern clinic, which had been regularly inspected for years, mainly without incident, reported a particularly agonizing occasion after the governor of the state publicly announced he was considering a run for president:
- “This year it was different. They were here for two days...they kept asking me to leave the room and they’d get on the phone with somebody in [state capitol]...then, they’d come back and ask to see such and such...I mean, it went on and on... someone else was pulling the strings.”

- 28 A clinic director in the South told of an inspection that involved nurses from the state health department, dressed in hazardous material suits, sifting through the clinic's garbage dumpster due to unfounded accusations from Operation Rescue members that aborted fetuses were being discarded there. This dumpster search—which drew puzzled stares from patients watching through the clinic windows—occurred in a period in which the clinic was involved in a high profile challenge to some of the state's restrictions law.
- 29 At the other extreme, some within the clinic world were told of health department inspectors who took pains to be helpful and made clear their dissatisfaction with the often blatantly politicized nature of their assignments. For example, a clinic manager in one Midwestern state recounted how one state inspector “went above and beyond” by giving her advice on upgrading the classification of her lab techs, making them eligible to become lab directors after a certain period. This tip, the staff person went on to say, came because the inspector realized the current lab director was aging and likely would be retiring in the near future. But, given the politics that inevitably surround abortion in “red” states, even those health department personnel who express their sympathy for clinics typically do so surreptitiously. “I’m your friend, not your foe,” one health department employee told clinic employees in a Mid-Atlantic state, “but you can’t repeat that publically.”
- 30 Even if hostility is not blatant, repeated inspections can create disruptions in clinic proceedings and are demoralizing to staff and upsetting to patients. One of the most frustrating aspects of the inspection process is that in many instances, these visits are unannounced and in some cases quite frequent (one clinic reported receiving such surprise visits eleven times in an eight month period, including two separate visits on one memorable day). As one staff person said :
- “So, it’s always with a sense of dread when I get that call from Security [that a state inspector has arrived] but I bring him or her upstairs and I ‘dance’, and we are found to be ok.”
- 31 Even when the inspection goes well, however—“well” in this case meaning that the clinic is found to be in compliance with recently passed regulations—the inspectors’ visits can be highly disruptive to clinic operations (and expensive—one director quoted a figure of \$800 for each unannounced inspection). As one manager said :
- “They come in, they commandeer a whole room for a day, a room that we really can’t spare, they demand all kinds of files, there is a tremendous drain on staff time, and patients—who are already nervous about their procedures—are rattled by these people with briefcases, who come off like FBI agents.”
- 32 Staff in one Midwestern clinic, which had recently seen an intensification of inspections, told of “men with guns” abruptly entering the clinic and “freaking out” both staff and patients. These were DEA—Drug Enforcement Administration—agents (who routinely are armed) who came, the staff assumed, because of an unfounded anti-abortion complaint about improper dispensation of drugs. In answer to a question as to whether, given the enormous political pressures involved on inspectors, there was still “integrity” in the inspection process, one clinic staff person told of her educational efforts with inspectors:
- “The people who come here aren’t ideologues necessarily—the people who send them here are. But if I get them [health department employees] in a room, I talk about social justice, about why we are here, I talk about [our founder] and why it matters that we survive....I give them a big dose of philosophy while I am showing them our narcotics logs....I really try to get across to them that...we’re not who the

antis portray, that we're not all money grubbing leeches just trying to make money off women."

- 33 Frustrated as they were with the repeated, unannounced inspections, some clinic staff spoke sympathetically about the bind of many health department inspectors in the new regulatory climate after 2011. As one clinic consultant in a state that abruptly imposed ASC requirements observed, "They do care about public health, they do have a sense of professionalism....of course they have political stuff they have to answer to, but they are not a bunch of wackos." She continued, "This whole thing [new state regulations that mandated unannounced inspections] got thrown at them too...their heads were spinning! The guidelines they had to follow had never been used in the state before...they were answering these questions in real time for themselves before they could answer them with us. They were thrown under the bus, too.

Impact of restrictions

3: Newer staff and threats to the "institutional memory" of women-centered abortion care

- 34 Given the fairly high turnover of junior staff in many abortion facilities, dealing with newer hires' confusion and upset is one of the major challenges clinic managers face as a result of the intensified level of scrutiny I have described. For example, one clinic director whose facility was subjected to an unusual amount of inspections because of complaints from the group Operation Rescue, said:

"I noticed the staff internalizing the criticism from the Right...I noticed [the newer] staff feeling like 'maybe, we are bad if somebody says enough times that what you are doing is bad....so it's really challenging for me as a manager when you start to see the stigma taking hold."

- 35 Quite poignantly, several senior clinic staff compared the current state of siege they felt from the current regulatory climate to the large scale blockades the abortion provider community experienced in the 1980s, and worried about the impact of the more recent events, particularly on newer staff. These staff ruminated about the differing levels of public support clinics received in each era. As one of these veterans put it:

"The blockades were really public, and they were physical. And so you dealt with them on a physical level...but people on the outside saw it, and they sympathized with us. The police came, they were on our side...but now, with the onslaught of attacks through the regulatory system and the legislative system, it's invisible to the majority of Americans—people have no idea what's happening. It's not thugs invading our clinic, it's state sanctioned harassment, and it's easier [for newer staff] to internalize."

- 36 Most worrisome to senior staff is the possibility that junior staff will accept the demands of the new regulations unquestioningly, and in the process, lose the veterans' vision of what good abortion care ideally should be. To explain further how ASC regulations actually effect on-the-ground abortion care, and in particular, the requirement of conforming to the sterility standards of hospital operating suites, this means in practice that all personnel encountering the patient during the procedure and after—not just those medically attending the patient—must be gowned and masked; that no pictures can be hung on the walls of procedure rooms or recovery rooms (because of dust); that the long-time practice of clinics having journals in their recovery rooms where patients can

write reflections or notes of support to future patients must be abandoned (again because of dust); and the equally longstanding custom of offering patients tea and snacks in the recovery room after their abortion was also forbidden.

37 As one veteran manager put it:

“As you make hires, and as they come in—every new nurse, every new medical assistant—they think that these ASC regulations are the actual standard of what abortion care should be... They entirely practice to the regulation, without an understanding that we do that bullshit part because we have to. The institutional memory of our field is being lost.” In this instance, the speaker was specifically referring to the fact that the clinic could no longer offer herbal tea or heating pads to patients in the recovery room because of the hospital-level sterility regulations now in force.

38 The irony of having freestanding clinics turned into essentially small hospitals was not lost on a woman, now a clinic consultant, who has worked in the abortion field ever since the Roe decision in 1973. As she commented in a focus group discussion:

“In the first ten years post-Roe, our whole mission as independent providers was about pulling this caring service out of a hospital situation. We fought really hard not to be in a hospital or an ambulatory surgi-center—which wasn’t even invented yet!—but being able to offer personalized care in a woman-to-woman manner that the safety of the procedure certainly made possible...we would care for women in a way that make it as personal and as good an experience as you could possibly have...And out of this came the idea of special touches...[we wanted] the women to feel like somebody went out of their way to help you feel comfortable today.”

39 The speaker went on to recount how she and a colleague had approached various herbal tea makers to find a blend that would be most helpful in soothing a woman’s uterus after the procedure.

40 Her statement was followed by others who were nodding their agreement. As one counselor put it,

“It’s really hard to maintain intimacy when you have a mask on, or when you have a weird hat on your head [of the type worn by surgeons] and you’re holding someone’s hand and you have this gown on. ...the overarching message to me is that they [new regulations] are interfering with the intimacy you have with the patient.”

41 In a similar vein, another long time clinic director, with tears in her eyes, said that after making the mandated ASC changes,

“You walk into our surgery center, and it’s so cold, and intimidating...there’s no art. The lights are too bright, the recovery rooms smell like bleach. Everyone’s wearing gowns. We have actually implemented doulas, but they’re still gowned up in the same things. The warmth is gone.”

42 In light of their perception of the threats that ASC regulations in particular posed to their career-long commitment to “quality” abortion care, members of the abortion providing community, including those participating in this study, were particularly heartened by a passage in Justice Stephen Breyer’s Majority decision in the Whole Woman’s Health case, where he was responding to the state of Texas’ argument that the few existing ASCs in the state could meet the needs of Texas women: “[I]n the face of no threats to women’s health, Texas seeks to force women to travel long distances to get abortions in crammed-to-capacity super facilities. Patients seeking these services are less likely to get the kind of individualized attention, serious conversation, and emotional support that doctors at less taxed facilities may have offered. Healthcare facilities and medical professionals are

not fungible commodities. Surgical centers attempting to accommodate sudden, vastly increased demand...may find that quality of care declines” (Whole Woman’s Health 2016, p. 35-36).

- 43 While the non-physician providers under discussion here would question Breyer’s exclusive focus on the role of doctors in the abortion experience, they were deeply gratified by his acknowledgement that the actual character of abortion care matters—a first in abortion jurisprudence.

Conclusion: Reproductive Governance and Abortion Exceptionalism

- 44 How, in conclusion, should we comprehend the situation described in this paper: that a new, intensified regulatory regime governing abortion care since the 2010 elections has emerged, and has brought such evident difficulties to this field? If, as the anthropologists Faye Ginsburg and Rayna Rapp (1995, p. 1) suggest, reproduction can be used “as an entry point to the study of social life,” then one might reasonably find that the reproductive politics of the contemporary United States reveal a society deeply conflicted about sexuality and women’s autonomy. More concretely, even though polls consistently show a majority of Americans wishing abortion to remain legal (PollingReport.com 2017), this majority is seemingly approving of, or more likely, oblivious of, the massive restrictions on abortion provision that have been enacted in recent years. The public’s passive acceptance of these restrictions is arguably yet another indication of the continuing stigmatization of abortion some forty-five years after legalization.
- 45 To return to the ideas presented at the beginning of this paper, I argue that the two concepts of “reproductive governance” and “abortion exceptionalism” help us understand what has transpired with the clinics. Abortion exceptionalism, again, conveys the idea that abortion as a health care service has been treated differently—and more harshly—by the regulatory arms of various states than have comparable out-patient health services, a point that was resoundingly affirmed by the Supreme Court in the *Whole Woman’s Health* decision. The aspect of the reproductive governance paradigm most clearly pertinent in this instance is that of *legislative controls*: the precarious situation of abortion provision in the United States, in simplest terms, is due to state legislators who, complicit in abortion exceptionalism, have implemented over 300 restrictions since the 2010 election. But these legislative actions exist in a mutually reinforcing universe with the other mechanisms named in the reproductive governance formulation:
- 46 1. The *economic inducements* cited by Morgan and Roberts can, in the abortion case, more properly be understood as *economic disincentives*. For example, the Hyde Amendment forbids any federal dollars being used for abortion services, except in very limited circumstances, and a growing number of state laws curtail the ability of private insurance plans to cover abortion, if these plans wish to be listed on a state’s exchange under the Affordable Care Act. Though some 15 states do allow state Medicaid funds to be used for abortions, the authorized reimbursements in many instances are so low that clinics actually lose money on these transactions. The lack of public funding for abortion has put providers in a difficult position. The average price of a first trimester abortion is about \$550.00, representing a negligible increase in the 40 odd years since *Roe*, when the price of a 1973 abortion was about \$150.00. But given that abortion patients are

disproportionately poor—some 75% are near or below the poverty line (Guttmacher Institute 2016)— providers feel constrained from raising prices.

- 47 2. The negative *moral injunctions* pertaining to abortion are arguably omnipresent in American society, ranging from the religious figures who denounce abortion and threaten excommunication of politicians who support it; to political figures, such as the current president of the United States, who has stated that women who have abortions should be “punished” (Flegenheimer and Haberman 2016), (a statement later retracted), to the distortions of abortion in popular culture (Sisson and Kimport 2016) and to the ideological messages contained in some laws, such as the one in Kansas essentially forbidding abortion providers from setting foot on public school grounds—a distinction, surely not lost on legislators, that puts these providers in the same category as sex offenders (Joffe 2013).
- 48 3. *Direct coercion* in the abortion case is most dramatically revealed by the eleven individuals who have been murdered by anti-abortion zealots and the thousands of others in the abortion providing community who have been terrorized at their homes and workplaces (Cohen and Connon 2015).
- 49 Though the *Whole Woman’s Health* Supreme Court decision in 2016 brought some welcome relief to this field, at the time of this writing in the fall of 2017, with the Supreme Court only one Justice away from a majority in favor of overturning *Roe*, abortion care is as embattled as ever. To be sure, the abortion providers interviewed for this study, by definition, were among the more fortunate in their respective states in that they managed to keep their clinics open, even in the face of expensive and cumbersome restrictions, while other facilities in their states were forced to close. Nevertheless, as I have argued, complying with these restrictions takes a considerable toll on clinic managers and staff, involving much added labor to already demanding work. What, finally, keeps the abortion providers discussed here committed to doing this work, in the face of these challenges?
- 50 Not surprisingly, providers responded to this question by citing a profound belief in the importance of reproductive justice and a very direct sense of commitment to their patients. As a director of a Midwest clinic, which has a long history of being picketed by aggressive protesters, put it: “It’s because of the patients...Because when you go into a room and you can hold the patient’s hand and she says, ‘thank you for being here,’ it makes it worth it. You temporarily forget about the five people who just threatened to beat you up...[I stay] because I love this work.” In a similar vein, a veteran clinic director discussed how the very process of campaigning, with local political officials, to protect her facility against draconian regulations improved her morale and that of her staff: “So we’ve been talking a lot about independent abortion provision with people who don’t know anything about abortion—except they have a lot of power to influence things about abortion...and this [campaigning] has reminded us of the really good things we have been able to do, and I think it’s offset some of the trauma we’ve gone through.”
- 51 But this ability to stay involved in abortion care is fueled also by a determination to not let the “antis” win. A senior staff person from a city in which national anti-abortion groups had made significant (and unsuccessful) attempts to shut the one remaining clinic down, acknowledged that that “what keeps her going,” beyond a commitment to her patients, is the satisfaction at having stood up to her foes. “They [antiabortion forces] did not stop abortion in — because we are there and it pisses —[nationally known leader of

antiabortion group] off, and that feels good to me...at the end of the day that asshole's sitting right down the street and he knows we're still here. That gets fire in my belly."

- 52 For some of those interviewed, even my raising the issue of how they managed to remain in this field, given the challenges, was met with puzzlement. As respondent said to this writer, "Carole, *there's joy in this work.*"

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ABSTRACTS

This article discusses the impact of the recent wave of abortion restrictions on abortion provision in the United States, a phenomenon that has led to the closing of numerous clinics. The article offers some context of the political forces that led to this expansion of restrictions, and describes two of the most consequential ones: Ambulatory Surgi-Center (ASC) requirements, which dictate that clinics conform to the physical specifications of small hospitals; and hospital-admitting privileges ones, which mandate that doctors providing abortions obtain privileges at local hospitals. I draw on research I have conducted with abortion providers in nine "red" or conservative states that have imposed new restrictions or intensified the monitoring of existing ones. I show how responding to this new regulatory environment, which includes a greatly

intensified schedule of surprise inspections, has consequences for the daily operations of the clinic, for the morale of both staff and patients, and for senior staff's ability to sustain and transmit to junior staff their original vision of woman-centered care. I conclude by suggesting that the current regulatory regime governing abortion care in many states represents an extreme example of "reproductive governance," a recent concept in the social science literature on reproduction.

Cet article explore comment la récente vague de restrictions législatives en matière d'avortement a conduit à la fermeture de nombreuses cliniques. L'article examine comment contexte politique a favorisé l'essor de ce type de mesures. Il se penche également sur l'exemple de deux de ces mesures dont l'impact a été conséquent : la première requiert que les cliniques pratiquant des avortements se conforment aux normes demandées pour un centre de chirurgie ambulatoire (*ambulatory surgical center*), la seconde exige que les médecins pratiquant des avortements soient autorisés à admettre leurs patients dans un hôpital proche (*admitting privileges*). Il s'appuie sur des recherches menées auprès de cliniques qui pratiquent des avortements dans neuf états « rouges », autrement dit conservateurs, ayant imposé de nouvelles restrictions ou ayant intensifié l'application des mesures déjà existantes. Il démontre que s'adapter à ce climat de régulation, qui a eu pour effet d'intensifier le rythme des inspections surprises, a des conséquences certaines sur le quotidien d'une clinique, sur le moral du personnel et des patients, sur la capacité des médecins expérimentés à fournir une qualité de soin axée sur les patientes tout en transmettant ce modèle à leurs jeunes collègues. Il suggère en conclusion que le système actuel de régulation qui régit la prise en charge des avortements dans de nombreux États est un exemple, poussé à l'extrême, de « contrôle reproductif », concept émergent en recherche en science sociale sur la reproduction.

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