On Becoming an Abortion Provider

An Interview

SHANNON STETTNER AND “DR. JAMES”

In October 2012, when I was gathering contributions to this collection, I interviewed an abortion provider whom I had first met more than a decade earlier through our mutual activism—his with Medical Students for Choice and mine with the Ontario Coalition for Abortion Clinics. For reasons of safety—both his own and his family’s—he has chosen to use a pseudonym, “Dr. James.” The original interview, which was conducted via email, has since been updated slightly, but it is for the most part unchanged.

SS: How and why did you make the decision to be an abortion provider?

Dr. J.: I don’t remember the exact moment that I decided to become an abortion provider. I have always been pro-choice, and, growing up, I was somewhat insulated from the anti-choice movement. I say this because I helped two friends contact abortion clinics but didn’t really consider the fact that there was so much opposition or difficulty in
obtaining the procedure. When I moved away for my undergraduate studies, I became heavily involved in the LGBTQ movement, and the reproductive aspect of my “sexual rights” work took a back seat. It wasn’t until a few years later that I realized that Guelph, a city of a hundred thousand, did not have an abortion clinic!

I decided to apply to medical school during my time at the University of Guelph. I was sitting in a philosophy of feminism class, and we were discussing systems of oppression and equality-seeking movements, and it became clear to me that medicine could be both a tool of oppression, through unequal access to health care, and a tool of social justice, by working with equality-seeking groups. Women’s health became the key reason I chose to pursue medical studies.

Early in medical school, I became involved with Medical Students for Choice, and, after my first conference, I was determined that this was something that I had to do. I could not simply be a pro-choice feminist physician. I could not stand up for women and not provide abortions. It was simply a matter of principle.

But I realized that it takes more than just principle to become an abortion provider. As I matured through my medical training (from the lectures to the first days on the ward as a student, through my internship, residency and fellowship, and in early practice), it became clear that no one ever “just” becomes an abortion provider. At each step in the process, one must consider the practical aspects: obtaining training, finding mentors, establishing a practice, and seeking support from other colleagues. This is often done under a cloak of secrecy for fear of reprimand. In addition, I was taking this journey along with my partner, who has been unwavering in his support for me and my decision. I concede that the “difficult ethical challenges” have never really bothered me—most of them are back-door excuses for justifying restricting access to abortion—but staying the course was harder than I expected.

There is no one reason why I am proud to provide abortions. Having daughters helps, and I care very deeply for my patients, even the ones whom I meet only for a few minutes. Knowing that I play a part in what will nearly always be an important moment in a woman’s life is something that I consider a privilege.

SS: What does “choice” mean to you? Is it still an adequate term to describe the movement for reproductive autonomy?
Dr. J.: Choice means having the opportunity to achieve greatness on one’s own terms. Choice also reinforces the fact that women who choose abortion are making a maternal choice in doing so—it’s the best option for both her and the pregnancy.

I think there are three problems with “choice,” the term. First, simplifying the abortion issue to one of choice and autonomy minimizes the complexity and depth that women explore when making a decision about their pregnancy. Choice implies a proactive decision (“If I get pregnant, I’m having an abortion”), whereas, for many women, the choice to have an abortion is reactive—many factors go into the abortion decision. I have yet to see a woman who is completely cavalier about having an abortion or is choosing to have an abortion “just because.”

Second, most women I see who choose abortion do so with the best interests of the potential child in mind, not because they like the idea of having an abortion. So, even though the abortion is her choice, a woman may be choosing to undergo a medical procedure that she does not especially want because it is the right thing to do in the circumstances.

Third, “choice” implies the ability to follow through on that choice. But the barriers that exist for women who need access to reproductive health services have little to do with the demand for these services—with women’s choice to seek them out. Our greatest challenge as health care providers is that we are unable to adequately provide for the members of our community.

I do believe in the paradigm of “choice,” but it could be insulting to suggest that one need only choose, and the abortion happens. These issues are complex and extend beyond reproductive rights, and to fix them as medical professionals and community builders will require us to examine our own power and privilege carefully—a process that is slow moving.

SS: How does performing abortions affect you professionally?

Dr. J.: Every abortion provider whom I know, myself included, cares deeply about each and every patient—whether I have cared for them for other reasons and have an ongoing relationship, whether I have just met them in the office, or whether I am just asked to be the technician to carry out the procedure. I sometimes wish that I had more time to convey this emotion to the patient. For me, professionally, I am able to say unequivocally that I provide the full spectrum of reproductive care to my patients, which is something that gives me great pride.
I have also had the privilege of providing abortion care to women with complex medical issues, women who are at very high risk if the pregnancy continues, as well as in special circumstances such as fetal anomalies and fetal deaths beyond the first trimester that require emergency care. Having the skills to manage these patients, particularly when few others will, is very rewarding.

SS: How does performing abortions affect you personally?

Dr. J.: Personally, I am affected by abortion in different ways. I am an adoptive parent, and as such, I belong to a community of families that have not historically been very pro-choice, if for no other reason than that of supply and demand: more abortions mean fewer potential children to be placed for adoption.

I empathize with those who want to become parents through adoption, and I see adoption support as being a part of reproductive health and social justice. I also cannot imagine my life without my children. I recognize that they were born of unintended pregnancies, and I’m not sure if, when the time comes for them to form their own identities, they will take exception to the fact that other pregnancies conceived in a similar circumstance will end in abortion.

That said, I have had women tell me they feel guilty about choosing abortion when couples are waiting for children. And I have patients who are experiencing infertility express frustration that their treatments are not funded when “abortion is free.” To be clear—even when my partner and I were unsure whether our desire to become parents would ever be fulfilled, I would never ask a woman facing an unintended pregnancy to carry a pregnancy to term simply because of my desire to become a parent. No woman owes me this. She must come to that decision on her own and not be coerced by an external party.

I think that being an adoptive parent, an obstetrician, and an abortion provider allows me to stand proudly in support of all pregnancy options. I know that each option can be the right one for the right patient, and I will do my very best to support whatever decision is made.

SS: Can you reflect more on your thoughts about adoption in relation to your experiences as an adoptive parent?
Dr. J.: I think adoption is a wonderful thing, and, like abortion, many people who haven’t experienced it seem to have strong and varied opinions about it. I have seen adoption being thrown around by both anti-choice groups (many so-called crisis pregnancy centres are affiliated with adoption agencies) and pro-choice groups (some of whom see it as an unacceptable alternative to abortion).

My observation is that many prospective families—adoptive parents in waiting—are not fond of abortion. I wouldn’t go as far as to say they are anti-choice. I think many couples are hurting and come to adoption because of infertility. They struggle with the fact that abortion services are covered in most provinces whereas infertility services are not. Adoption is their Plan B, and their fate as parents rests in the hands of women with unintended pregnancies, many of whom go on to choose abortion.

My other observation is that a lot of birth mothers are pro-choice. Many were late in diagnosing their pregnancy, and others are pro-choice but feel that abortion isn’t the right choice right now. Some prospective birth mothers consider adoption before moving to abortion. This observation, of course, is limited to a few patients and women whom I have met who have placed children into adoptive homes. It reminds us not to presume we know what someone else is thinking or where they stand on an issue.

Not being infertile, I can’t really relate to the concerns I have mentioned. Adoption has always been my Plan A, as I believe that biology does not a family make. Above all else, though, I wanted my children to be raised knowing that adoption is what their birth parents wanted for them. The thought of a woman being coerced into adoption over abortion is as unacceptable as being forced into parenthood, and I could never ask that of a woman. So I continued to provide abortions while we waited to become parents. Oddly enough, I specifically remember my lack of an emotional response to the first abortion I performed after becoming a parent. I was worried that I would feel different or would struggle—but the case went on without hesitation. Perhaps being a parent has made me realize just how ready one should be before embarking on such a life-changing event.

SS: I know from the work of Medical Students for Choice, among others, that there is concern over the availability of training for abortion procedures in Canadian medical schools. Can you reflect on your experiences as someone who has gone through the process recently?
Dr. J.: The challenge in recruiting physicians to become abortion providers lies in the apathy and lack of coverage of family planning in most medical school curricula. In an attempt to avoid a “hot topic” for fear of offending students (usually those who are anti-choice), medical schools have removed the social responsibility of physicians as community advocates and removed the medical aspect from what is, at the end of the day, a medical procedure. If students don’t know how prevalent abortion is, how to counsel patients appropriately, and how much work some women must do to access one of the most common medical procedures in North America, how are they supposed to make a difference?

There is a second challenge: once medical students develop an interest in abortion, much of their education on the subject and the procedure itself is self-directed. I know of no other area of medical education where students have to work so hard just to get trained. It does not get easier in residency. Many programs have an opt-in approach, so the default position is that you do not learn about abortions.

I will say that my experience in seeking training was largely positive. Organizations like Medical Students for Choice allow students to network in a safe space, and students always leave conferences energized to further their skill set and knowledge. Many OB-GYN faculty members support a woman’s right to choose, even if they don’t provide abortions (a bit hypocritical, yes), so there is support to get training; the hard part is sticking it out. It is certainly unnecessarily hard, and I am hopeful that more MSFC alumni will find ways to make it easier for new learners to acquire these important skills.

SS: Although there is no abortion law at present, doctors continue to be the “gatekeepers” to abortion. Some pro-choice advocates argue that abortion should be a decision a woman makes “in consultation with” her doctor, while others would have the physician be more of a “rubber stamp,” for lack of a better term. As an abortion provider, what do you perceive as your role in the abortion decision?

Dr. J.: I really see my role as a facilitator. Very few women come to an abortion clinic or request a referral for an abortion without having done most of the decision making themselves. I think there is a role for counselling, but we border on paternalism by requiring all women to speak with a counsellor first. I recognize that I am a gatekeeper, and I take that role seriously—I hope
I never inadvertently abuse that power. I see the pendulum swinging away from comprehensive counselling to “informed choice.”

One hot topic for “gatekeepers” currently is gender-selection abortion (particularly with patients being able to determine fetal sex very early in the pregnancy), as well as other “less socially desirable” reasons to choose abortion. There certainly are many physicians, and also clinic workers, including counsellors and nurses, who will restrict access to an abortion if they don’t agree with the reason. I worry that any blanket restriction is a slippery slope. I have not faced an overt example of this in my own practice, which leads me to believe that its prevalence has been exaggerated.

Allow me to meander slightly. There have been media reports recently about gender imbalances in certain areas—in particular, areas where there are large immigrant populations. The media allows viewers to draw their own conclusions about where the girls are going, but we have no idea whether (a) sex-selective abortion occurs with significant regularity, or (b) the gender imbalance isn’t also affected by other practices (cessation of child-bearing once a male is born, pre-implantation sex selection at the time of IVF). These also contribute significantly to imbalances.

SS: Dr. Ellen Wiebe has contributed a piece to this collection, in which she discusses providing abortion services to patients who are anti-choice. She surveyed women having abortions and discovered that just over half (54 out of 102) thought that there were some reasons why women should not be allowed to have abortions. It’s interesting that such an apparent lack of empathy can exist among women who are going through the same experience. It’s also interesting that women feel a need to justify their own abortions as somehow having a level of “merit” that they don’t allow to other women. Do you have any thoughts on that? Or on the idea that women need to have “good enough” reasons to have an abortion?

Dr. J.: I’m always cautious about separating the women who are quietly against all or some aspects of abortion but who go on to have abortions (probably most of the women in Dr. Wiebe’s study) from those who are vociferous opponents of abortion, who use fear and inaccurate information to trick women, and who then go on to have an abortion for their “superior” reason. The reality is that all women, pro-choice or not, those who have had abortions and those who have not, have been bombarded with messages about their bodies, their reproduction, and abortion their entire lives. It is extremely hard
to ignore all of the baggage we bring with us on the ride. And few women expect to be having an abortion, even though one out of three will. If a woman must justify her own abortion as being for a better reason than the woman beside her, so be it—but she should keep her opinion to herself.

I always wonder how those same women would answer six months after their abortion, or after they become parents, if they were not already parents when they had an abortion. I suspect that these women were asked before their abortions occurred, a time when many women experience feelings of shame and guilt. (Post-procedure, these are generally replaced with relief and positive thoughts.) Asking them when they may still be in that “apprehensive” phase may not accurately represent their true feelings. I bet you would see less anti-choice sentiment over time.

SS: Judgments of women who have had an unplanned pregnancy can be pretty harsh. It’s not uncommon to hear criticisms of women for failing to use birth control at all or for not using it properly. Yet birth control fails, and human beings are flawed—sometimes bad decisions get made, especially in the “heat of the moment.” Women speak of being pressured to go on birth control after an abortion, as if the assumption is that they’ve been irresponsible. While I understand wanting to provide women with contraception, pushing birth control pills on a woman who has just aborted seems to contain an implicit judgment of her. What are your thoughts on this? How do we address the stigmatizing of women as irresponsible?

Dr. J.: I think that the stigmatization of patients as being irresponsible is a common paternalistic view within medicine. It cannot possibly be us, because we have birth control options to offer—we have pills and IUDs and public health nurses who can say the names of body parts without blushing and doctors who can write prescriptions. Surely, it is her fault. The reality is that unintended pregnancy is a problem for both women and their health care providers. Half of all unintended pregnancies occur as a result of contraceptive failure. Contraceptive failure happens because of multiple factors, and I cannot tell you which one specific aspect causes it for each specific woman.

We use many colloquialisms to describe unplanned pregnancy: in trouble, knocked up, up the duff, with child. We sexualize women and yet judge them when they get pregnant without planning to. I see no short-term solution to that problem other than to acknowledge that none of us is immune to our exposure to such terms.
I am sorry that women sometimes feel insulted when doctors talk to them about birth control. In practice, most women who have chosen abortion or who are postpartum are quite motivated to prevent pregnancy, and my recommendation to start birth control is not meant to be punitive. I actually think we tend to underprovide birth control to women who are post-abortion and postpartum.

SS: Reading the stories of women’s abortions submitted for this collection, I was struck by the differences in the attitude of their partners. Two of the women were well supported by the men in their lives, but several others weren’t, which really underlines the truth that the responsibility for conception, maternity, and fertility falls unevenly on the women. As a physician and a provider, do you have any thoughts or reflections on this observation?

Dr. J.: My views on this issue have evolved. At first, my initial feeling was that some of the burden is self-imposed. For example, we did a study on couples and found that most women made the decision to have an abortion before involving their partners, which means they had to journey that decision-making process alone. I think the way in which we have developed the abortion clinic model, in an attempt to empower women, further segregates her burden of choice from his deference to her decision. The more I see women in my practice, even though many of the partners I see are supportive, I agree, the burden does fall on women. As a physician and a provider, I fear I have little more to offer, though there is a recognition in the family planning community of a need for more male-led contraceptive options.

As a man and a father in a nontraditional family, I struggle with society’s privileging of maternity over paternity. I’m just the dumb dad. I’m not expected to be openly affectionate to my children, or to share in parental roles, or to know when my baby is mad because she hates her car seat and not because she’s hungry. But I also see how my family—a two-male-led household—is threatening to some. The only solution to this inequality is for society to encourage men to take on a greater parental role and allow women to delegate without shame. But, as men’s roles change, we will have to engage in a greater discussion about how we allow men to have opinions (I’m not saying they should have a vote) about their partners’ pregnancy decisions.

SS: I think what you’re saying here is really important, and there’s a lot to unpack in your answer. As a woman who is resolutely pro-choice,
unquestionably I see women as the final arbiters. As a movement, we have largely avoided the issue of men’s place in the decision—generally denying the existence of a place—because there is a fear of creating an opening whereby a man can compel a woman to continue an unwanted pregnancy. But, as you indicate, by so doing, we also cement the “burden of choice” as something a woman too often faces alone.

Dr. J.: Exactly. The choice to have an abortion is directly related to one’s reproductive autonomy. I believe that it is not only a woman’s choice but often a maternal decision. I agree that men are not entitled to the final say, though I think it’s healthy for couples to communicate and share in stressful life events—it’s what you sign up for when you enter a relationship. I guess my conundrum is that I’m not sure whether it’s a “burden” when a woman chooses to make the decision without consulting a partner (which I absolutely support) and whether it is “empowerment” or “burden” when a male partner defers to the decision to the pregnant woman. If there is an element of burden being placed, then I think we have to spend some time teaching men that it is very “manly” to be a supportive partner.

SS: In a couple of the narratives in this collection, the women make comments to the effect that they didn’t want to become “women who have had abortions.” Much is implicit in those statements—the stigma that is still associated with abortion, the secrecy, the shame, as well as the recognition that the procedure ends a potential life. It’s odd that there’s so much shame associated with a procedure that approximately one-third of Canadian women have undergone. One contributor to this volume, an abortion counsellor, wrote: “We all know women who have had abortions, although we may not know that we do.” Why does the shame, silence, and secrecy continue to surround abortion? Why don’t we talk about abortion? How do we go about ending the secrecy? Can or should we be talking about and understanding abortion differently?

Dr. J.: As long as clinic workers feel unsafe or are murdered (and, like me, stay silent publicly about the work we do), as long as women lack complete control over their bodies, as long as our society oppresses women, and as long as the media tiptoes around the issue or only covers it as an ethical issue, I don’t see this improving. I think there are some wonderful grassroots movements afoot to increase the conversation about abortion, but I also
think women have a right to privacy, and this must be respected.

SS: Do you have concerns for your safety? If so, how does that affect your practice and life?

Dr. J.: My first priority is the safety of my family—my partner and my children. We do have some tactics that we employ to fly under the radar, but it is hard at times to be an advocate in public and still have a private life. While I am proud of what I do, I am not always forthcoming with the specifics of my job description.

I am fortunate to work in a city with very little protest activity, but the city also has a history of anti-choice violence, including an attempted murder, so there is an institutional memory that commands additional safety measures. I sometimes park a little further away and walk. I check to see if people are following me to my car. I work in locked clinics. I always worry what kind of message we send to patients when we tell them that this is their right and their choice, and we support them, but we are going to hide the clinic in the basement in this derelict area and we'll put security guards at the entrance. No wonder women keep it a secret!

Would I die for this cause? Yes. I think that most providers would agree with me on that. But I very much hope it doesn't come to that. We have already lost some very good doctors and clinic workers. I still can't wrap my head around how the anti-choice movement supports such violent murders.

SS: It's easy to see the outcome of that fear and secrecy. A number of contributors to this book express feeling isolated and unsupported through their abortion experiences. One woman wrote: “The worst part of this whole experience was the shame and isolation.” I believe that we, as pro-choice advocates, need to better support women who require support. Some women don't need post-abortion support, but some do. My personal belief is that the Silent No More movement (and comparable movements) preys on women who were more emotionally vulnerable post-abortion and who didn’t—for whatever reasons—get the support they needed. Do you have thoughts on the adequacy of pro-choice post-abortion support available to women who need it?

Dr. J.: We are terrible at this, and we have been since the beginning. I have a clipping from the Ottawa Citizen about Norma McCorvey, the woman
behind *Roe v. Wade*. The reason she is no longer pro-choice is that the movement used her and then pushed her aside when they were done with her. From the very first patient, we got it wrong!

I think the clinic setting is not the right place for post-abortion support—it’s too value-laden a place. I’m surprised there aren’t more Web-based resources for this in the age of social media and message boards. Sometimes, I think that we as a profession and movement are afraid of the fact that some women regret their decision, and that’s why we don’t want to engage in post-procedure support.

**SS:** If you see the clinic as too value-laden, where is a more ideal setting for counselling?

**Dr. J.**: Hospital-based clinics and public health units could easily take the talking aspect out of the procedure room and move it elsewhere. I think that referring physicians and family health teams could make use of their spaces as well.

**SS:** I think your comment about how the lack of post-abortion support may reflect some sort of fear on our part is important. Many women make the decision to have an abortion while they’re in a state of crisis—whether because becoming a parent would totally disrupt the planned trajectory of the woman’s life or because the circumstances of her life (relationship problems, money issues, etc.) make the pregnancy a crisis. Then, when the pregnancy is terminated, the sense of desperation dissipates and the woman starts to second-guess herself. Either way, the lack of post-abortion support needs to be addressed.

**Dr. J.**: The analogy that comes to mind is from the LGBTQ community. When I came out and realized how supportive people could be and saw LGBTQ youth coming out younger and younger, I really felt a sense of regret about not coming out sooner. But I think it’s easy to forget the context in which we make decisions once that life context changes. So, in that sense, I completely sympathize.

This is why it is so important that women feel supported in that time of need so that, when they look back, their memory of that challenging time is of a group of people who cared for them unconditionally and gave them the opportunity to find their power again.
SS: How do we go about changing the abortion experience for women so that it is neither shameful nor isolating?

Dr. J.: We need to slowly become visible again. We can have bubble zones and clinic protection and privacy without being completely anonymous. Go to five hospitals with abortion clinics and you’ll see five different euphemisms for abortion: Family Planning Clinic, Women’s Health, Surgical Centre, Procedure Clinic, and so on. Let’s call it what it is.

Within the clinics themselves, we need to create a sense of community—comfortable seating, up-to-date colour schemes, tea in regular mugs, places for women to journal or draw or sit together or hold each other. A place for partners to be present and supportive and relieved and to be able to say, “Thank you for doing this.” Doctors need to be willing to hold a patient’s hand if she wants, and laugh if she wants, and tell her that she or he supports her and takes his or her role in this part of her life with honour. We get so bogged down with the procedure, and we don’t stop to consider the experience. Yes, these women become “women who have had an abortion,” but why does that have to be a negative? To me, it’s a time of great courage and strength.

SS: Another theme that weaves through several of narratives I’ve read is that of forgiveness, of women needing to forgive themselves for their choice. One contributor, for example, wrote, “I know this is something I’ll have to forgive myself for. . . . The pain isn’t in the choice. It’s in finding the peace in it.” Do you have any reflections or thoughts on that?

Dr. J.: It will come with time. I believe that the decision to have an abortion is a maternal decision, one made with the potential child in mind first and foremost. Trust yourself and your decision, for only you will ever be in that exact moment and circumstance.

Note