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CHAPTER 1

Abortion and medicine: A sociopolitical history

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LEARNING POINTS

- Abortion was apparently widely practiced in the ancient world, with mention of the procedure in some of the earliest known medical textbooks.
- Physicians, as well as lay advocates, have always played an active role in social movement activity concerning abortion, sometimes promoting legal abortion, and less often, opposing it.
- Today about two-thirds of the world's women live in societies where abortion is legal, but the bare fact of legality per se masks considerable differences among countries as to the availability of abortion services and the social climate in which they exist.
- Compared to other advanced industrialized societies, the contemporary USA is the extreme example of a society in which an antiabortion movement arose in response to legalization and ultimately managed to become a leading force in domestic politics.
- Currently, the movement for safe, legal, and accessible abortion has assumed a transnational character, with joint activities of physicians from both developing and developed countries having an important impact.

Introduction

"(T)here is every indication that abortion is an absolutely universal phenomenon, and that it is impossible even to construct an imaginary social system in which no woman would ever feel at least compelled to abort [1]." So concluded an anthropologist after an exhaustive review of materials from 350 ancient and preindustrial societies.

Beyond the stark fact of its universality, abortion throughout history exhibits a number of other distinctive features. First is the willingness on the part of women seeking abortion and those aiding them to defy laws and social convention; in every society that has forbidden abortion, a culture of illegal provision has emerged. Second, to a far greater degree than is the case with most other medical procedures, the status of abortion has been inextricably bound up with larger social and political factors, such as changes in women's political power or in the population objectives of a society. Finally, the mere fact of legality does not necessarily imply universal access to abortion services. Crucial factors in the availability of abortion include the structure of health care services, and especially the willingness of the medical profession to provide abortion.

With these points in mind, this chapter presents a brief historical overview of abortion provision, including the role of social movements among physicians and other clinicians in both facilitating and impeding the availability of abortion services.

Abortion in the past

Throughout recorded history, populations have risen and declined in ways that cannot be attributed solely to natural events such as plagues or famines. For example, a marked decline in population occurred in the early Roman Empire, despite prosperity and an apparently ample food supply [2]. Such events suggest that individuals in past societies vigorously sought to regulate their fertility; they did so by use of abortion and contraception, and also by practices of child abandonment and infanticide [3].

To give some sense of the ubiquity of abortion in the premodern world, consider the following: Specific information about abortion appears in one of the earliest known medical texts, attributed to the Chinese emperor Shen Nung (2737

Management of Unintended and Abnormal Pregnancy, 1st edition. By M Paul, ES Lichtenberg, L Borgatta, DA Grimes, PG Stubblefield, MD Creinin
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to 2696 BC); the Ebers Papyrus of Egypt (1550 to 1500 BC) contains several references to abortion and contraception; during the Roman Empire numerous writers mention abortion, including the satirist Juvenal who wrote about "our skilled abortionists"; and the writings of the 10th-century Persian physician Al-Rasi include instructions for performing an abortion through instrumentation [2, 4].

Most interesting, perhaps, is the reinterpretation that some scholars have given to the famed Hippocratic Oath (400 BC), which has long been used by abortion opponents to argue that the so-called Father of Medicine opposed abortion. These scholars argue that the passage commonly translated as "Neither will I give a woman means to procure an abortion" is rendered more correctly as "Neither will I give a suppository (also translated as 'pessary') to cause an abortion." According to this view, Hippocrates was urging a ban on one form of abortion that he considered dangerous to women, but was not condemning the practice generally. Indeed works ascribed to Hippocrates describe a graduated set of dilators that could be used for abortions, as well as prescriptions for abortifacients [2, 5].

The rise of the Christian era brought more public regulation of sexual life, including increased condemnation of abortion. Open discussion of abortion techniques lessened, as did direct abortion provision by physicians. Until the 18th century, therefore, abortion and contraception became largely contained within a women's culture. Midwives in particular became key providers of abortion and family planning services, for which they were periodically persecuted as "witches [2, 6]."

Despite shifting opinion about abortion and organized medicine's reluctance to engage with the issue, early monotheistic traditions did not hold the strong, unified position against abortion that is now associated with the contemporary Roman Catholic church. While early Islamic teachings prohibited abortion after the soul enters the fetus, religious scholars disagreed about when this event occurred, with estimates ranging from 40 to 120 days after conception [7]. Early Christian thought was divided as to whether abortion of an early "unformed fetus" actually constituted murder [5]. The Catholic church tacitly permitted earlier abortions, and it did not take a highly active role in antiabortion campaigns until the 19th century.

In Europe and the USA, the 17th through the 19th centuries were an especially interesting period in abortion history. On one hand, advances in gynecology, such as the discovery (or more correctly, rediscovery) of dilators and curettes, meant that physicians could offer safer and more effective abortions. On the other hand, the conservatism of the medical profession regarding reproductive issues prevented widespread discussion and dissemination of abortion techniques. As three longtime scholars of abortion have noted, "The combination of medicine with anything concerning sex appears to have a particularly paralytic effect upon human resourcefulness. This has been especially true in the field of abortion... [8]."

At the same time that the medical profession responded ambivalently to patients' requests for abortions, a widespread culture of abortion provision by others flourished. Abortion providers, including midwives, homeopaths, and other self-designated healers, as well as some physicians, advertised freely of their willingness to help with "female problems" and of potions and pills that would "bring on the menses [5, 9]." This commercial provision of abortion remained largely unregulated by law until the 19th century. Under the prevailing standard, abortions performed before "quickening" were not regulated at all, and attempts to police later abortions were minimal. In England, it was only during Queen Victoria's reign that the Offences against the Person Act of 1861 passed, which made surgical abortion at any stage of pregnancy a criminal act [7]. In the USA, a vigorous antiabortion campaign was launched around 1850, and by the 1870s, all states had criminalized abortion.

Notwithstanding involvement on the part of Catholic and Protestant clergy and others, physicians were the leading force in the campaign to criminalize abortion in the USA. The American Medical Association (AMA), founded in 1847, argued that abortion was both immoral and dangerous, given the incompetence of many practitioners at that time. According to a number of scholars, the AMA's drive against abortion formed part of a larger and ultimately successful strategy that sought to put "regular" or university-trained physicians in a position of professional dominance over the wide range of "irregular" clinicians who practiced freely during the first half of the 19th century [5, 9].

What followed was a "century of criminalization" characterized by a widespread culture of illegal abortion provision. Thousands of women died or sustained serious injuries at the hands of the infamous "back alley butchers" of that period, and encountering these victims in hospital emergency rooms became a nearly universal experience for US medical residents [10]. However, safe abortions were available to some women, performed by highly skilled laypersons [11] and physicians with successful mainstream practices who were motivated primarily by the desperate situations of their patients. These "physicians of conscience" were instrumental in convincing their medical colleagues of the necessity to decriminalize abortion. By 1970, the AMA reversed its earlier stance and called for the legalization of abortion [10].

This overview of the history of abortion suggests several themes. Besides the omnipresence of the desire for abortion, the record of very early understanding of abortion techniques and actual abortion provision by some sectors of the medical profession are striking. This knowledge, however, was willfully forgotten as abortion became socially controversial and the medical profession avoided the issue for the most part. Consequently, until quite recently in the developed world (and continuing today in many developing

nations), two parallel streams of abortion provision emerged: a minimalist one, by physicians, only to selected patients under narrowly specified conditions, and a broader extralegal one, in which a variety of providers with widely ranging skill levels offered abortion services.

What is less clear to contemporary scholars is the degree of safety and effectiveness of abortion provision before the widespread legalization that started in the latter half of the 20th century. Ample documentation attests to the many injuries and deaths that occurred before legalization in the USA and elsewhere, and that continues today where abortion remains illegal. However, given the historical record that points to the persistent search for abortions in all cultures and at all times, without death records to match this volume of abortion, some observers suggest that many illegal abortions were relatively safe, although probably painful and unpleasant [2, 3, 6]. What remains indisputable is the greatly improved safety record once abortion is legalized. In the USA, abortion-related mortality declined dramatically after nationwide legalization, eventually reaching 0.6 deaths per 100,000 procedures between 1979 and 1985, "more than 10 times lower than the 9.1 maternal deaths per 100,000 live births between 1979 and 1986 [12]."

New technologies, new organizational forms

Around the period of legalization in the USA, technological advances in the field of abortion care facilitated new models of abortion delivery. Specifically, development of the vacuum aspirator, cervical anesthesia methods, and the Karman cannula all improved the safety of abortion and permitted its provision in nonhospital settings.

The vacuum aspirator, introduced to US physicians in 1968 at a landmark conference on abortion sponsored by the Association for the Study of Abortion, lessened blood loss and lowered the risk of uterine perforation compared to the older method of dilation and sharp curettage [13, 14]. Cervical anesthesia techniques allowed clinicians to manage procedural pain using local injections rather than the more risky general anesthesia. The Karman cannula, invented by a California psychologist who had been involved in illegal abortion provision in the 1960s, was composed of plastic rather than metal. This soft flexible cannula facilitated provision of early abortion using local anesthesia and made perforation less likely [8]. The widespread adoption of the Karman cannula represents a vivid example of a larger phenomenon: the extent to which, as abortion services rapidly expanded after legalization, the medical profession was compelled to seek the advice of a number of illegal abortionists, both lay and physician [10].

Taken together, these innovations in abortion methods catalyzed the creation of the freestanding abortion clinic, which was pioneered in the USA. Washington, DC, and New York City had liberalized their abortion laws several years before the *Roe v. Wade* decision, and clinics in these cities attracted women from all over the country. These clinics were able to offer safe outpatient abortion services at lower cost, and often in a more supportive manner, than hospital-based facilities. The creation of the role of the "abortion counselor"—someone specifically trained to discuss the abortion decision with the patient, explain the procedure, and support her throughout the process—was a distinctive contribution of this early period in legal abortion [15]. These clinics also were instrumental in pioneering a model of ambulatory surgery that became widely adopted by the medical profession.

Freestanding clinics remain the dominant form of abortion delivery in the USA, while in Europe and Canada, abortions are more evenly spread between clinics and hospitals. Notwithstanding the many benefits of the freestanding clinic model, it also has contributed to the marginalization of abortion services from mainstream medicine in the USA and left clinics more vulnerable to attacks from antiabortion extremists. In contrast, those European countries where abortions are delivered as part of national health care systems have experienced less difficulty in finding providers and far less antiabortion activity at service sites.

Medical abortion (Chapter 9) is another technological innovation that has permitted new categories of abortion providers to emerge in many parts of the world. Mifepristone, approved in France in 1988 but not in the USA until 2000, is gradually taking hold and bringing a number of primary care practitioners to abortion care. In 2005, a national survey of US abortion providers by the Guttmacher Institute revealed that medical methods comprised 21% of abortions provided at 8 weeks' gestation or less [16]. Midlevel clinicians (also referred to as advanced practice clinicians) deliver mifepristone medical abortion services in many states in the USA and in certain developing countries where abortion is legal, such as South Africa. Finally, misoprostol, the drug commonly used in conjunction with mifepristone for early medical abortion, has received increasing attention within the medical community for its ability to terminate a pregnancy when used alone. Evidence suggests that access to misoprostol has reduced morbidity and mortality from illegal abortions in the developing world (Chapters 2 and 22) [17].

Abortion in sociopolitical context

By the early 1950s only a handful of countries had legalized abortion; however, in the last half of the 20th century, an "abortion revolution" of sorts occurred. As a result, nearly three-fourths of the world's women now live in countries where abortion is legal either in all circumstances (up to a certain point in pregnancy) or when specific medical or social conditions are present [18]. Major forces leading to this liberalization included recognition of the health

costs of illegal abortion, with the medical profession often acting as key advocates for legalization; the rising status of women, and especially the entry of women into the paid labor force, which led feminist groups to mobilize on behalf of abortion and improved contraceptive services; and, to a lesser degree, various countries' explicit interests in limiting population growth.

However, the bare fact of legality per se masks considerable differences among countries as to the availability of abortion services and the social climate in which they exist. The contemporary USA is the extreme example of a society in which an antiabortion movement arose in response to legalization and ultimately managed to become a leading force in domestic politics. However, abortion remains controversial in many other countries as well, with periodic attempts by both abortion rights supporters and their opponents to modify existing arrangements.

Europe and North America

Nearly all the countries of Western Europe that did not already have liberal abortion laws underwent progressive abortion reform in the 1970s and 1980s. Following unification of East and West Germany in the early 1990s, Germany became the one case of a European Community (EC) member that adopted more restrictive laws than had existed previously [19]. In the contemporary EC, Ireland and Poland represent the only countries that do not permit abortion, presenting baffling issues about how to reconcile their strict antiabortion policies with the more liberal policies of the others. Although EC member countries are free to devise their own abortion policies, they theoretically give free access to citizens who wish to travel to other member nations. The conflict between these two principles has emerged periodically, as exemplified by several notorious cases in which the Irish government attempted to prevent women in dire circumstances from traveling to England for an abortion. In a 2007 case, "Miss D.," a 17-year-old carrying a fetus with anencephaly, had her passport confiscated in order to prevent such travel. After numerous court hearings (and litigation estimated to cost 1 million euros), she was finally permitted to go to England [20].

In general, Western Europe has had a quite stable abortion environment. In contrast to the situation in the USA, access to abortion-providing facilities in Western European countries (with a few exceptions) is substantially easier, with most offering subsidized abortions for health indications and many for elective abortions as well. Moreover, abortion provision in these countries is largely free from the extremes of violence and controversy that have characterized abortion care in the USA. Such differences testify to the important role that national health care systems play in assuring access to abortion care. The European and US comparison also reveals that the centrality of abortion in US political culture is almost unique among advanced Western democracies.

Eastern Europe

In 1920, Russia was the first country in the world to legalize abortion (although it reversed its stance in 1936 and then later reestablished legalization). By the 1950s, all the countries of Eastern Europe had legalized abortion. This reform occurred primarily because of the various regimes' needs for women to enter the paid labor force, rather than as a response to women's demands for reproductive freedom or concerns about the consequences of illegal abortion. In the absence of adequate contraception in most Eastern bloc countries, abortion became an accepted method of fertility control, and abortion rates were among the highest in the world [21].

After the fall of communism in 1990, a number of Eastern European countries experienced pressures to reevaluate abortion policies. Contributing factors included the renewed power of the Catholic church in some cases, as well as the association of abortion with the discredited policies of the old Communist regimes and the corresponding "sentimental perceptions of a pre-Communist world where home and family were paramount [19]." Hungary and Slovakia restricted their abortion policies somewhat, and they continue to have conflicts about this issue. However, the most dramatic reversal took place in Poland, which moved from a policy of abortion on demand to one that permitted abortion only in cases of severe fetal malformation or serious threat to the life or health of the pregnant woman [21]. The new legislation, strongly advocated by the Catholic church, called for imprisonment of doctors who performed unauthorized abortions. Not surprisingly, as pointed out in a recent publication by a reproductive rights group in Poland tellingly titled *Contemporary Women's Hell: Polish Women's Stories* [22], women in that country have an extraordinarily difficult time obtaining a legal abortion. The group estimates that only about 150 legal abortions take place in the country each year. "This is mainly because doctors do not want to take responsibility for consenting to a legal abortion. Women are sent from one doctor to another, referred for tests that are not legally required, and misinformed about their health...For doctors...such women represent problems that need to be eliminated as quickly as possible [22]."

As is typical in all societies that restrict abortion, Polish women who can afford it travel to clinics in other countries or find doctors within Poland who are willing to provide illegal abortions (often costing as much as US $1,000) [22]. Those without such resources often resort to attempts at self-abortion; abandonment of newborns in maternity hospitals; illegal adoptions; and in some instances, according to press reports, infanticide [23].

Although Poland has the most visible antiabortion movement in Eastern Europe, the former Soviet Union also has experienced a backlash against abortion and family planning efforts. At the same time, abortion supporters (both medical and lay) in Poland and various republics of the former

Soviet Union are part of the global reproductive rights movement, from which they gain resources and the support of colleagues. The Polish publication cited earlier, for example, was translated and printed with financial aid from Ipas and the International Women's Health Coalition, organizations that are based in the USA but whose focus is international. Similarly, various US foundations have funded training programs in medical abortion and manual vacuum aspiration for physicians in various parts of the former Soviet Union.

Canada

Historically, Canada's abortion reform centered largely on the activities of one individual, Henry Morgentaler, a physician who has repeatedly challenged that country's abortion laws since 1968. Morgentaler's crusade culminated in the 1988 Canadian Supreme Court decision, *R. v. Morgentaler*, which removed abortion from Canada's criminal code [24, 25]. However, abortion policies still differ considerably from province to province, with various restrictions put forward by antiabortion legislators and some provinces (especially in the Maritimes) having a shortage of providers. Although in no way approaching the level of US antiabortion activity, Canada has experienced several incidents of violence directed against abortion providers, as well as destructive acts at clinic sites. Canada has not yet approved mifepristone, but methotrexate regimens are used for early medical abortion.

USA

The 1973 *Roe v. Wade* decision that legalized abortion throughout the USA resulted in large part from mobilization among the medical community and feminist groups [26]. This ruling quickly gave rise to an antiabortion movement, which in its degree of political power and its willingness to engage in violence and intimidation makes the US abortion situation unique. As of 2007, some seven members of the abortion-providing community (physicians, receptionists, a volunteer, and an off-duty police officer employed as a clinic security guard) have been murdered, and thousands of others have been harassed at their workplaces and homes [27]. Due to stiffened federal penalties for antiabortion violence and disruption established during the Clinton presidency in the 1990s, these incidents have diminished in number, if not in seriousness.

During the two presidential terms of George W. Bush (2000–2008), the climate for legal abortion in the USA worsened considerably. Acting on the recommendations of religious right leaders, the President appointed two new conservative justices to the US Supreme Court. In 2007 these two justices provided the margin needed in *Gonzales v. Carhart* to uphold the federal Partial-Birth Abortion Ban Act of 2003, the first ever federal ban on certain abortion procedures. The actions of Congress and the Court were unprecedented in their willingness to ignore the best judgment of the medical community: the American College of Obstetricians and Gynecologists (ACOG), the National Abortion Federation, and Planned Parenthood Federation of America all had decried the ban, arguing that banned procedures were the safest option in certain circumstances [28]. Adding to the dismay of abortion rights supporters, the majority in this case for the first time found constitutional an abortion restriction that did not have an exception for women's health. The federal ban adds to the massive number of restrictions that already exist at the state level to curtail women's access to abortion, especially for the most vulnerable (Chapter 4).

The Bush presidency also brought the spread of abortion politics to other issues, as the religious right gained enormous political leverage within the administration. Attacks on stem cell research, promotion of discredited "abstinence only" sex education programs, and cutbacks in contraceptive funding, both domestically and internationally, were only some of the steps taken by President Bush to satisfy his right-wing base. The Bush administration was noteworthy as well for making inappropriate, ideologically driven appointments to important governmental posts. For example, the credentials of the physician selected as head of all government-funded contraceptive programs included his service as medical director of an agency that declared birth control to be "degrading"; similarly, prospective appointees for both domestic positions on scientific panels and assignments to the Coalition Provision Authority in Iraq were vetted on the basis of their opinions of *Roe v. Wade* [29].

Enhanced mobilization among health care providers associated with the religious right also occurred during the Bush years. Groups such as the Christian Medical and Dental Associations, Pharmacists for Life, and "pro-life" caucuses within ACOG and other medical associations worked in various ways to impede access to abortion and contraception. A number of individual pharmacists and some pharmaceutical chains, for example, have refused to fill prescriptions for emergency contraception; some pharmacists have even refused to fill prescriptions for regular oral contraceptives, on the alleged grounds that these medications constitute abortifacients [30]. Moreover, the large number of mergers between Catholic and secular hospitals that have occurred in the USA has compromised delivery of abortion care and other reproductive health services, such as family planning, sterilization, and assisted reproduction [31, 32].

The abortion rights medical community in the USA has mobilized as well, particularly since the mid-1990s, in reaction to growing evidence of an abortion provider shortage and the unacceptable level of violence occurring at clinics. The formation of Medical Students for Choice (MSFC) in 1994 represents a particularly important development. The group has chapters on most US medical school campuses, as well as physician activists in more than 200 residency programs in obstetrics and gynecology and other fields (Backus, personal communication, 2008). One of the group's first activities was to successfully help pressure the Accreditation

Council for Graduate Medical Education (ACGME) and the Council on Resident Education in Obstetrics and Gynecology to mandate abortion training in obstetrics and gynecology residency programs (with opt-out provisions for those with religious or moral objections) [33]. This positive step was nullified in part by the US Congress when, in an unprecedented intrusion into medical affairs, it stipulated that those residency programs that failed to conform to this standard would not lose federal funding. Nonetheless, the revised ACGME guidelines have substantially increased abortion training in the USA [34, 35].

Other health care professionals, particularly primary care practitioners, have spearheaded efforts to expand abortion training and access. Family practice and other primary care physicians have organized to increase abortion training opportunities [36] and legitimatize abortion provision within primary care medical institutions. Groups similar to MSFC have emerged among advanced practice clinicians (nurse practitioners, nurse midwives, and physician assistants) committed to safe and legal abortion care. Not all of these health professionals will necessarily become abortion providers themselves, but one can reasonably assume that they will be supportive of their colleagues who do (Fig. 1.1).

The establishment of the Kenneth J. Ryan Residency Training Program and the Fellowship in Family Planning (see Appendix) also has been pivotal in assuring the vibrancy of the abortion provider community in the USA. By offering technical and financial assistance, the Ryan Program helps obstetrics and gynecology and family medicine residency programs integrate abortion training into their curricula. The Fellowship in Family Planning, established in 1991 at the University of California at San Francisco, offers postgraduate training (including clinical and research experience, as well as an international component) to physicians who are committed to abortion and contraceptive work. Numerous graduates from this fellowship have assumed positions as faculty and directors of family planning divisions in leading medical institutions, thereby increasing the visibility of abortion in US medical culture [37].

Figure 1.1 Efforts to increase abortion training opportunities and legitimatize abortion provision within primary care medical institutions and the emergence of groups like Medical Students for Choice (MSFC) have been pivotal in assuring the vibrancy of the abortion provider community in the USA.

Professional organizations such as the Association of Reproductive Health Professionals and Physicians for Reproductive Choice and Health, comprised of both individuals who provide abortion and those who do not, also have been important advocates for safe and accessible abortion. Both groups have argued forcefully that reproductive health practice and policy must be based on scientific evidence, not on personal or religious beliefs. The National Abortion Federation, the professional association of abortion providers in the USA and Canada, establishes evidence-based guidelines for abortion care and offers its members continuing medical education as well as opportunities for community building (Fig. 1.2) (Appendix).

Developing countries

Except in a few countries such as China and India, most women in the developing world do not have access to legal abortions, although changes are under way in a number of places. In some situations of formal illegality, women can still obtain safe abortions, as in certain large cities of Latin America or in the menstrual regulation clinics in Bangladesh, Malaysia, and Indonesia. Nonetheless, some 65,000 to 70,000 women die each year from unsafe abortion, primarily in developing countries, and thousands of others are seriously injured (Chapter 2).

Two United Nations (UN) conferences, the International Conference on Population and Development held in Cairo in 1994 and the Fourth World Conference on Women held in Beijing in 1995, were noteworthy for the centrality of debates over abortion and reproductive rights. In spite of vigorous opposition from the Vatican and a few Catholic and Muslim nations, a coalition of feminists from both developed and developing countries managed to push the final conference documents in a far more progressive direction than had previously been the case. Language was approved that acknowledged the right of women to control their fertility and that called for greatly expanded family planning services. The documents also recognized that abortions take place, whether legal or not; that in those countries in which it is legal, abortion should be safe; and that women who have unsafe abortions should not be prosecuted and should have access to adequate health care services to manage

Figure 1.2 Members of the National Abortion Federation, the professional association of abortion providers in the USA and Canada, benefit from continuing medical education as well as opportunities for community building.

complications [38, 39]. The Cairo and Beijing conferences did not create any mechanisms for implementing these recommendations, and the 10-year follow-up discussions at the UN brought similar political cleavages [40]; nonetheless, these conferences established a critical precedent in the international community by situating abortion and reproductive health in the context of basic human rights.

In the decade that has passed since these two crucial meetings, a number of countries in the developing world have liberalized their abortion policies, including Nepal, Colombia, and various Caribbean nations, as well as Mexico City. In the summer of 2007 leaders of ten African nations, including the Vice-President of Kenya, called for the legalization of abortion as a response to unacceptably high mortality rates among African women from unsafe abortion [41]. At the same time, however, other countries have regressed in their abortion policies. Nicaragua and El Salvador, for example, have instituted strict policies prohibiting abortion, even to save a woman's life [42, 43].

Conclusion

In considering the contemporary status of abortion, we can speak of a "cup half full, half empty" quality to this highly controversial issue. On the negative side, too many women still suffer injury or death from unsafe abortion, and too many women are forced to carry unwanted pregnancies to term. Too many abortion providers face unacceptable threats of violence and intimidation, as well as restrictive legislation that may include criminal penalties. On the positive side, some countries where abortion has been previously illegal are starting to liberalize their laws. Recent developments in abortion care, such as medical abortion and the return of manual vacuum aspiration, have made abortion care safer in various developing countries and have enlarged the pool of abortion providers in developed countries, including the USA.

The history of the relationship of abortion and the medical profession reveals an inescapable connection between abortion provision and social movement activity on both sides of the issue. This connection will only intensify in the foreseeable future. Clinicians who support abortion rights, along with their lay allies from the reproductive justice movements, will continue to mobilize in various ways to establish or expand abortion care, while antiabortion activists will attempt to thwart them at every turn.

More so than in the past, however, the activities of these social movements within medicine are assuming a transnational character. As patients, medications, and Internet information have crossed borders, abortion-related activism has globalized as well. Physicians affiliated with the US-based antiabortion movement engage in numerous international campaigns against abortion and contraception. One recent campaign, for example, warned of the coming "demographic winter" of too many Muslim births and not enough Caucasian ones in European countries [44].

Within pro-choice medical circles, groups such as the International Federation of Professional Abortion and Contraception Associates and the International Federation of Gynecologists and Obstetricians focus on the medical aspects of abortion care, and International Planned Parenthood Federation has long worked on issues of access as well. Global Doctors for Choice (GDC) is a particularly promising recent addition to these international efforts on behalf of safe and legal abortion. A loose confederation of physicians in various countries, GDC activities integrate medicine and advocacy directed at governmental bodies, transnational policy makers, and organized medical institutions. In a number of countries where abortion is contested or remains illegal, GDC-affiliated physicians have engaged in various advocacy efforts: they testified on human rights issues at international tribunals (Ireland); participated in coalitions that organized successfully for liberalized abortion laws (Mexico City; Portugal); and worked on innovative ways to reduce

mortality from unsafe abortion (e.g., the "harm reduction model" pioneered by doctors in Uruguay) (Chavkin, personal communication, 2008). Many of the physicians who participate in these transnational movements speak of gaining a sense of community and solidarity with colleagues worldwide, which is no small benefit for those who work in such a contested area of medicine.

In sum, significant obstacles to abortion access, safety, and services persist in many parts of the world. Nonetheless, the steadfast commitment of pro-choice physicians and other clinicians offers hope that the goal of normalizing abortion as part of women's reproductive health care is gradually drawing closer.

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