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Self-Sourced Medication Abortion, Physician Authority, and the Contradictions of Abortion Care

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Abstract The growing acknowledgment of the phenomenon of individuals terminating their pregnancies by obtaining the medications necessary for an abortion—which this article refers to as "self-sourced medication abortion" (SSMA)—has shed light on the current contradictions in the world of abortion provision. This article offers a brief historical overview of the relationship between abortion provision and mainstream medicine, pointing to the factors that have led to the marginalization of abortion care. It then discusses interviews with 40 physicians who provide abortions about their perspectives on SSMA, and it explores how this group responds to the contradictions presented by SSMA. In doing so, it interrogates the changing meaning of "physician authority" among this subset of physicians. The authors suggest that these interviewees represent an emergent sensibility among this generation of abortion physicians, a sensibility strongly tied to a commitment to social justice.

Keywords abortion, physician expertise, self-managed abortion, self-induced abortion, reproductive autonomy

The growing phenomenon of individuals managing their own abortions by obtaining the drugs necessary for a medication abortion—which we refer to in this article as "self-sourced medication abortion" (SSMA) (also called "self-managed abortion" or "self-induced abortion")—sheds light on the current contradictions in the world of abortion provision. On the one hand, abortion care has been marginalized from mainstream medicine in the United States, as evidenced by the low numbers of obstetrician-gynecologists (ob-gyns) and primary care physicians (PCPs) who provide

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abortions and the lack of abortion training in many residencies in both those fields (Kortsmit et al. 2020; Strasser et al. 2022). Hospitals and physicians' offices together only provide about 5% of the abortions that take place each year in the United States, and physicians' offices only slightly more than hospitals. Most abortions (about 95%) occur in free-standing clinics (Jones et al. 2019), and although these clinics offer excellent care, this has further exacerbated the separation of abortion from other medical institutions. Added to these issues is the stigma against abortion in American society, as evidenced by the more than 1,500 restrictions on abortion passed by hostile state legislatures; the violence, vandalism, and harassment that has become commonplace at clinics; and the continual attempts to have the US Supreme Court overturn the landmark *Roe v. Wade* decision, which finally succeeded in the *Dobbs v. Jackson Women's Health Organization* decision in June 2022. In response to this long-standing marginality, leaders in the abortion-providing community have worked tirelessly to normalize this care into mainstream health care institutions.

On the other hand, the FDA approval of medication abortion in 2000 has significantly contributed to the possibilities of the "demedicalization" of abortion care. This method of abortion, in contrast to the other major methods of abortion, does not involve instrumenting the uterus. Rather, it involves assessing a medical history for the few contraindications to the medicines, determining the duration of a pregnancy, and instruction about the timing of taking the two relevant drugs, mifepristone and misoprostol. To be clear, here we are addressing the issue of self-induced abortion only using medication abortion drugs; most pertinent to the issue of demedicalization is the availability of these drugs on the internet or through pharmacies in other countries and personal connections (Jerman et al. 2018). Several studies have shown that this can be done safely and effectively outside the medical setting, and without seeking medical assistance in most cases (Harris and Grossman 2020; Karlin et al. 2021; WHO 2015). Researchers estimate that about 7% of American women (Grossman et al. 2010; Ralph et al. 2020) have attempted their own abortion, either by obtaining these medication abortion drugs or by other methods, such as ingesting herbs and supplements (Grossman et al. 2015). This phenomenon is expected to grow as abortion access becomes more difficult (Aiken 2018; Biggs et al. 2019).

In this article, drawing on interviews with 40 physicians completed before the *Dobbs* decision, we explore how this group of experts responds to the contradictions presented by SSMA: the opportunity for user autonomy

and patient centeredness versus the loss of expertise in the demedicalization of the process. In expressing their support for SSMA, these physicians share a critique of medical authority and a belief that institutional medicine can inadvertently cause harm, particularly to those most vulnerable, including patients of color, low-income people, and minors. However, as we will show, their responses to SSMA also reveal yet another contradiction in the world of abortion provision: despite the pull toward patient autonomy as represented by SSMA, these physicians are ambivalent about giving up their own direct involvement in abortion care, as they find this work so meaningful.

We discuss not only how the contradictions of abortion care are currently playing out—normalization and inclusion within mainstream medicine versus demedicalization—but also the struggles of a group of doctors who are grappling with the meaning of medical expertise. We suggest that the physicians interviewed represent an emergent sensibility among the current generation of abortion physicians, one strongly tied to a commitment to social justice. Of course, it can be argued that any clinician who chooses to participate in abortion care likely has strong social and political commitments, given the very real career consequences, not to mention the threats of harassment and violence, that often accompany this branch of health care. Nonetheless, by elucidating this group's perspectives about demedicalizing a practice, we highlight how they incorporate the values of person-centeredness and autonomy into their identities, while devaluing physician expertise.

Historical Background

The history of abortion and the medical profession in the United States informs the contemporary struggles we write about here. In the 19th century, the newly organized American Medical Association (AMA) was the force that successfully led state legislatures to criminalize abortion, except in those cases where physicians felt an abortion was necessary to save the life of the pregnant person. The AMA's campaign has been interpreted as a professionalizing project—an attempt at differentiation between "regular" (allopathic) doctors and other healers, such as lay midwives and practitioners with lesser training, many of whom were involved in abortion provision (Luker 1985; Mohr 1978). Allopathic physicians argued that only they could provide safe abortions and had the professional expertise to make decisions about "medical necessity." Notably, this campaign was not about the morality of the procedure; rather, it was about the AMA's

drive for formal recognition from state legislatures as the organization representing a profession that could dictate the terms of medical practice and regulate other practitioners.

A century later, at the annual convention of the AMA in 1970, pro-choice doctors successfully convinced their colleagues to vote for the liberalization of abortion laws. Some of those who opposed this measure did so because they worried that demedicalization would question their expertise. During the 1960s and 1970s "radical" health movements that strongly questioned medical authority were flourishing. This was especially true of the feminist health movement of that era, whose critiques were particularly aimed at ob-gyns (Frankfort 1972). One participant in the AMA meeting in 1970, no doubt mindful of the feminist health activists marching outside the hall where the meeting was taking place, made this statement about the prospect of expanded abortion care: "Legal abortion makes the patient truly the physician: she makes the diagnosis and establishes the therapy" (Joffe 1995). At an earlier conference on abortion, even the famed ob-gyn Alan Guttmacher—a high-profile supporter of legal abortion—had voiced his discomfort at abdicating his role as a medical advisor and merely acting as a "rubber stamp" for women wanting abortions (Joffe 1995). In contrast to the activists who were calling for "abortion on demand," the AMA policy stipulated that abortion policy should be based on "sound clinical judgement" and not on "mere acquiescence to the patient's demand" (Petchesky 1984). In short, even though the supporters of liberalization won the vote, the proceedings of that meeting revealed an ambivalence about abortion provision that has lasted to this day among some portion of the medical profession.

In seeking to understand this passive stance toward the delivery of abortion *care*—in a period where most in medicine supported abortion *legality*—the legacy of abortion provision in the pre-*Roe* era is most relevant. Beyond the many thousands of women who attempted their own abortions, the pre-*Roe* era saw a variety of types of illegal abortion providers. These clinicians included those one of us has termed "doctors of conscience"—individuals who had successful medical practices and who were led to perform illegal abortions by viewing, in hospital emergency rooms, the ravages of attempts at self-abortion or ineptly performed procedures (Joffe 1995). Others who provided abortion care during that era, with varying degrees of success, included nurses, midwives, and laypeople. But the dominant image of the pre-*Roe* abortion provider, in both the popular imagination and the medical one, were the "back-alley abortionists," or, as they were sometimes referred to, the

"back-alley butchers." Although these terms could encompass those with medical degrees and those without, for those in medicine, the back-alley abortionists specifically meant doctors who were both medically inept and highly unethical, and whose abortion practice occurred because they were unsuccessful at sustaining an aboveground medical practice. Stories circulated in medical circles of the sexual assaults and alcoholism of these "butchers" as well as the injuries and deaths they caused—stories later confirmed in the published accounts of women who had undergone abortions with them (Messer and May 1994).

After the *Roe* decision in 1973, the medical profession did not take the steps that would be expected with the legalization of a procedure sought by so many. Rather, mainstream medicine responded with "equivocation," as observers at that time put it (Jaffe et al. 1981). That is, few hospitals established abortion services, and few ob-gyn residencies offered abortion training. The American Council of Graduate Medical Education, which oversees residency training, would not require abortion training for ob-gyn residents for another 20 years. Few national medical organizations offered guidelines about how abortions should be delivered (the American Public Health Association was a notable exception). In the few hospitals that did establish abortion services, the clinics tended to be staffed by the abovementioned "doctors of conscience," who had the most experience in abortion provision. As a physician at the time remarked about the small number of doctors providing abortions, "The rest of the staff regards these doctors with esteem not markedly higher than that previously reserved for the backstreet abortionist" (Jaffe et al. 1981). In short, the prediction that sociologist Everett Hughes made after the legalization of abortion in England, a few years earlier than *Roe*, could have easily been applied to the American situation: "Thus has an illegitimate want become at least formally legitimate; but that does not mean that those who satisfy the want will gain positions of prestige in the medical system" (Hughes 1971). Some among the first generation of doctors who provided abortion after *Roe* experienced the lack of "prestige" Hughes referred to as they were denied hospital privileges and tenured positions within academic medicine (Joffe 1995).

An additional factor that inhibited the incorporation of abortion into medical institutions after *Roe* were the very clear indications, to the then largely conservative medical profession, that the issue would be politically controversial. Well before the rise of an aggressive, sometimes violent grassroots antiabortion movement that would eventually target abortion providers in their clinics, the US Congress acted to constrain abortion

provision. In 1973, shortly after the *Roe* decision, Congress passed the Church Amendment, which stipulated a conscience clause for individuals and entities who refused to perform abortion. This was followed in 1976 by the Hyde Amendment, which forbade the use of federal dollars for abortion except under very limited circumstances.

Finally, the rapid growth of freestanding clinics, a phenomenon that had started in New York and Washington, DC, earlier in the 1970s, also contributed to the separation of abortion provision from mainstream medical institutions. Freestanding clinics developed as it became apparent that outpatient abortions could be provided safely. The clinics circumvented the far higher costs of hospital-based abortions and the problem of working with hospital staff who were opposed to abortion. Abortion clinics, both those affiliated with Planned Parenthood and independent ones, have amassed an excellent safety record and to this day provide most abortions in the United States. The downside to this reliance on freestanding clinics is that it has enabled abortion supporters within mainstream medicine to largely avoid the issue, such as by not offering abortions within their own practices, for example.

In response to their marginalization, physicians who support abortion access have taken steps to normalize abortion within medical institutions. They have secured funds for an abortion training program in ob-gyn residencies, the Kenneth J. Ryan Residency Training Program, which has a presence in more than 100 residencies in the United States. In the 1990s, these leaders similarly created a Fellowship in Family Planning that trains both ob-gyn and family medicine doctors in abortion-related research as well as advanced methods of abortion provision. Relatedly, ob-gyns successfully gained recognition for a new subspecialty, "complex family planning" (Schreiber and Madden 2021). Similarly, family medicine doctors, through programs such as RHEDI (Mainstreaming Abortion in Family Medicine; formerly Reproductive Health Education in Family Medicine) and RHAP (Reproductive Health Access Project), have obtained resources to support resident training in abortion and contraception. At regional and national medical conferences, pro-choice ob-gyns and PCPs have worked assiduously to ensure inclusion of abortion-themed sessions. The Society of Family Planning was established in 2005 to create a forum where academic researchers in the fields of abortion and contraception could present their work, and it has its own official peer-reviewed journal, *Contraception*. In recent years, as the political situation surrounding abortion has worsened, the medical wing of the pro-choice movement has successfully urged the leadership of relevant national medical groups to issue statements of support

for abortion provision (ACOG 2021). All these efforts are aimed at increasing the legitimacy and visibility of abortion care as a component of standard reproductive health care.

Abortion Providers Reflect on SSMA

It is against this historic backdrop of marginalization and attempts at normalization that the field of abortion provision is now confronting both the challenges and the opportunities presented by SSMA. In what follows, we draw on interviews from an IRB-approved study of 40 physicians about their evolving views of this phenomenon. The lead author initially surveyed and interviewed physicians who had provided at least three abortions in the last 6 months at the time of recruitment (to ensure active knowledge about medication and procedural abortion), which took place between March and July 2019. Targeted recruiting ensured a diversity of participants based on categories hypothesized to influence physician's perspectives: specialty, years of practice, generational differences, fellowship training, and practice location (by US state and varying supportive and hostile policy settings, based on the Guttmacher Institute's characterization of the policy landscape) and setting (Nash 2020). In addition to the demographics listed in table 1, participants practiced in a total of 24 states throughout the United States, with most in the West (n = 13, 32.5%) and the Northeast (n = 10, 25%). Using the abovementioned Guttmacher report, we found that about half of the interviewed providers worked in states with a predominantly supportive abortion policy environment, and half worked in states considered hostile or neutral to abortion rights (Nash 2020). These demographics mirror those of abortion providers in the United States, except that we oversampled family doctors because most of the abortion care that family doctors provide is medication abortion, rather than procedural abortion.

Before taking part in a 90-minute, semistructured, in-depth interview, participants completed a brief survey that included questions about demographics and a Likert scale about the safety and efficacy of eliminating clinical oversight of each step in a standard protocol for a medication abortion. Each participant began the interview by describing the values that underlie their practice of medicine. We then asked about perpectives and attitudes regarding SSMA. In the middle of the interview, we provided a fact sheet with resesarch regarding the various steps of SSMA and asked again if any of their attitudes had changed with this evidence. Finally, we

Table 1 Participant Demographics (N = 40)

Participant characteristics	N	%	Participant characteristics	N	%
Age (y)			Years since graduating residency		
26–35	20	50%	0–9	23	57.5%
36–45	9	22.5%	10–19	8	20%
46–55	8	20%	20–29	8	20%
56–65	2	5%	30–49	1	2.5%
66–70	1	2.5%	Years providing abortion care		
Gender			0–10	26	65%
Male	6	15%	11–20	8	20%
Female	33	82.5%	21–30	5	12.5%
Genderqueer	1	2.5%	31–40	1	2.5%
Race/ethnicity			No. of medication abortions/ month		
White, non-Hispanic	29	72.5%	3–20	28	70%
Black, non-Hispanic	1	2.5%	21–40	6	15%
Asian	7	17.5%	41–60+	6	15%
Hispanic/Latinx	2	5%	No. of procedural abortions/ month		
Multiracial	1	2.5%	3–20	17	42.5%
Religious affiliation*			21–40	8	20%
Christian	7	17.5%	41–60+	15	37.5%
Jewish	8	20%	Restrictive state		
Hindu	1	2.5%	More	16	40%
Atheist	6	15%	Less	24	60%
Agnostic	1	2.5%	Institution where providers do their abortion work*		
None	18	45%	Academic	14	35%
Other	1	2.5%	Primary care clinic	10	25%
Specialty*			Planned Parenthood	33	82.5%
Family medicine	31	77.5%	Other nationally affiliated family planning clinic	3	7.5%
OB/GYN	9	23%	Other locally based family planning clinic	14	35%
Internal medicine	1	2.5%			
Reproductive health fellowship					
Yes, family medicine	8	20%			
Yes, obstetrics	5	12.5%			
No	27	67.5%			

*Participants could select more than one group.

asked participants to reflect on how their values described at the beginning of the interview aligned with SSMA and to ascribe a narrative framework that fit best with their attitudes toward SSMA. Each interview was digitally recorded and transcribed verbatim. We analyzed the transcripts with Atlas.ti software using deductive-inductive directed content analysis (Hsieh

and Shannon 2005). A priori themes were based on domains from Fishbein's integrated model of behavior change and concepts derived from literature on medical professionalism (Fishbein 2009; Fox 1957; Light 1979; Stern 2006). We coded transcripts and iteratively reviewed them to identify discrepancies or redundancies as well as to identify emergent codes until intercoder consensus was reached. We approximated theoretical sufficiency at 40 interviews (Nelson 2017) and applied the final code book to all those transcripts and then dervied themes from the analysis.

One year following the initial interview, participants were invited to complete a follow-up survey that included the same previously assessed Likert scale and open-ended responses to questions focused on changes in their perspectives about SSMA during the previous year, and specifically in the context of the COVID-19 pandemic. Thirty-six participants responded, and four were lost to follow-up. Because the pandemic spurred significant changes in accepted protocols for the delivery of medication abortion, we interviewed 10 of the 36 respondents to further explore themes regarding changing views during this time period. For a complete description of this cohort and findings, please refer to "Greasing the Wheels" (Karlin et al. 2021).

Ceding Control and Concerns over Safety

Issues of SSMA safety are, unsurprisingly, a key concern for this group, and directly touch on the question of relinquishing physician control of the abortion procedure. Some interviewees acknowledged the difficulties of relinquishing the traditional role of the physician. As one respondent put it, "That's the problem with this [SSMA]. I am a doctor. I wasn't trained to let people do things at home without my input." She went on to say she had no experience "teaching people how *not* to use me." Another physician spoke of her dismay at seeing, in the southern states in which she works, patients who put "strange herbs in their vaginas." Her response to these attempts was to try to make the clinic as comforting and user-friendly as possible and to normalize the experience of SMMA for the individuals who told her about their failed attempts. However, she finished her thoughts by bluntly stating, "I guess the paternalistic side of me has this idea of, 'Well, I went through all these years of training. What's the value of training, then?'" One participant candidly admitted that her initial response to the concept of SSMA was to think of the notorious "coat hangers" and similar stories of the harm pregnant people did to themselves attempting self-abortions

in the pre-*Roe* era. She explained her reluctance to endorse SSMA by referring to the "very excellent messaging early on about abortion being health care."

Most participants, however, believe that demedicalization of abortion can occur safely. They trust that patients can become informed and correctly assess risk and maintain access to medical care if needed. Several interviewees also cited clinical experience and flexibility as critical to their comfort with handing over the reins to patients. One family physician explained, "I've already been in the practice of really acknowledging my lack of power and relinquishing control . . . working in a federally qualified health center with underresourced patients who at times have different health care beliefs. . . . They either can't or won't do what you say. . . . Can't do it due to financial situation reasons or they don't like what you say. . . . People are going to do what they want." In a similar vein, another participant said, "These things are happening regardless. Why not be able to do it in the safest way—like, support women in this process instead of criminalizing them? Allow them to live a life that they are trying to live with control over it." In this last quote, we see how a physician acknowledges that the locus of control and risk-taking can be centered around the patient rather than around the physician and the health care system.

Legal Concerns

More than concerns over safety, respondents were troubled by the legal consequences of SSMA primarily for patients but also for themselves. Frustrated by the ambiguous and threatening laws and policies in place even before the *Dobbs* decision, these physicians were cautions about the ramifications of SSMA. This fear of legal consequences corresponds with the findings of other studies of physician perspectives on SSMA (Baldwin et al. 2022); however, it does not align with patient concerns while self-sourcing (Madera et al. 2022).

We found that working in a restrictive state significantly affected risk aversion for physicians and decreased their support for new models of abortion care. One physician, in a state considered among those most hostile to abortion, voiced her concerns about even discussing SSMA with patients, although she acknowledged it might be a good option for some patients: "One patient was [over the gestational limit] and I told her she was too far for me to do the medication abortion. And she said, 'But I think I can get this online.' And I said, 'Well, that's not legal.' You know, we're told not to advise [about SSMA] because she could be recording me. I

mean, we have spies come in. So I just said, 'Well, I don't know what you'll do out there.' I don't want to get into trouble." While doctors protest these laws and policies, they also want to make sure they do not put their medical licenses or clinics at risk, so they act conservatively to avoid overstepping the legal bounds. Presumably, years of intense scrutiny have led to a more conservative attitude toward following protocols, even when those protocols do not adhere to medical evidence. Even a physician who was licensed to practice in several abortion-friendly states and who was extremely supportive of SSMA worried about the status of her medical license if she were to be actively involved in SSMA: "Clearly some states are worse than others for abortion provision. . . . It's not necessarily a legal issue so much as a professional liability issue that I worry about. If I wanted to openly encourage patients to do home medication abortion, then I would want to have the backing of the medical commission in the state where I am licensed. I would want to have the public backing of every professional group engaged in this work."

Physicians' legal concerns about SSMA also extended to patients, of course. One respondent allowed that SSMA may be appropriate for some patients but not for all: "Depending on the patient and who they told, and who their support network is, I can imagine a 15-year-old doing this at home and then having a 12-weeker [discernible as a fetus], and their mom finding out who's very religious or very conservative." Some mentioned worries that emergency room personnel, particularly in abortion-hostile states, would notify authorities if an SSMA patient showed up because of excessive bleeding. For example, a doctor in an abortion-hostile state who stated that SSMA "is totally congruent with my values" nonetheless worried about the possibility of the legal repercussions facing some patients: "Doctors need to know that they don't need to report that to the police. . . . Unfortunately, that's happened, as we know nationally. Women have gotten into trouble because emergency room staff have called the police." These legal concerns are not unwarranted. The legal advocacy group If/When/How has documented 61 cases during 2000–2020 in which people have been criminally investigated or arrested for attempting to manage their own abortion or helping someone else do so outside the formal health care system (Huss 2020). In the immediate aftermath of *Dobbs*, many of the legal concerns that respondents raised, such as the risks of discussing the option of SSMA with patients, remain unclarified, and several groups have been founded to support patients and doctors with legal and medical advice.

Reluctance to Give Up Abortion Provision

Nonetheless, even some of those who in principle acknowledge the safety and legitimacy of SSMA are reluctant to give up clinic-based care because—consistent with the research on abortion provision (Joffe 2010)—they find their work so deeply meaningful. As one doctor said, expressing a common sentiment, "There is something different about abortion work that feels like it's really important, that I'm doing a job that other people won't do, and that I'm just able to provide a really important service to patients that they're really grateful for, in a way that people are not necessarily grateful for in [other areas of] health care. [Abortion provision is] like a very, very easy way to feel good at the end of the day, which is not why I went into it . . . but I definitely think that's an ongoing motivator." In a similar vein, one doctor said ruefully, "As a family doctor, we want to be present for events that happen in our patients' lives. I think it might be a little sad for some primary-care doctors to have this event taken out of that space." Several respondents pointed to the camaraderie among those in their clinics involved in abortion care, a closeness we speculate is due—because of the stigma against abortion—to the sense of a shared mission held by those in this beleaguered area of health care. As one doctor said, "I really feel very fortunate to work in a place in which we have a small, very stable staff. And so it very much feels like a family when I come to work. That people are happy to see me. They know me, I know them. We have a shared history together, and the people are very motivated to be there for all the same reasons."

Conversely, a little more than half of the participants perceived taking pills at home as devoid of this relationship and support (n = 23). When asked what they valued about their abortion work, a family doctor from the Midwest explained, "I value being able to connect to patients, and I value being able to make patients feel heard and cared for and respected. I value that I'm able to help them come to terms with whatever decision they need to come to and that they feel like they can do so in a space and among people who don't judge them." To satisfy these values of rapport-building and destigmatization, these respondents feel that they need to be involved, even if people taking pills at home may be satisfied with their experiences (Madera et al. 2022).

We learned about the difficulty some physicians have with giving up their centrality in the practice of medication abortion when we asked about their ideal scenario of abortion provision. Most interviewees responded to this prompt in broad terms, acknowledging that there was not a one-

size-fits-all answer. The main themes that emerged from answers to this question were that ideally abortion would be safe, accessible, affordable, covered by insurance, destigmatized, evidence-based, normalized, painless, and an experience in which individuals can feel empowered, supported, informed, and in control. However, respondents often answered this question with a vision that idealized in-person abortion experiences. For example, a physician who had expressed hesitancy about SSMA earlier in her interview because of the safety concerns for some patients outlined an ideal vision of abortion care that would make SSMA less necessary: "Medication abortion should be available in every family doctor's and ob-gyn's office. So they could just call their doctor to schedule it, just like any other medical need or procedure. And then they could get in promptly. It would be covered by their insurance. They wouldn't have to walk through picket lines. They wouldn't have to have the stigma. They could share it with their family. They could share it with their doctors and then have it done safely under maybe medical supervision and then have good follow-up for any complications or problems." This physician could only speculate that those wanting to do SSMA were unable to access services free of stigma, even though the data indicates that there is a group of people with access to health care who prefer SSMA (Aiken et al. 2018). While other participants said SSMA achieved the ideals of patient autonomy and empowerment, even those who thought SSMA was safe and effective often used this question as an opportunity to express nostalgia about an earlier time with superior medical care, describing a completely medicalized environment. As one respondent reminisced: "I have an image based on 20-something years ago from California, of a great clinic in Northern California that just had nice, low lighting; wonderful hippie women with great, flowy, cotton dresses who were so kind to the patients and served them herbal tea." This participant highlights a more ambivalent stance toward SSMA while she prioritizes in-person care as the ideal way to offer normalized and supportive abortion care.

Nonetheless, half of the cohort could imagine including SSMA as one option within a spectrum of ideal abortion provision. One doctor voiced a common sentiment when she said, "The ideal service in my mind is what the patient wants, which could be different for different people and at different points." She went on to say, "For some people, [the right thing] is a very medicalized process of being completely put to sleep, and not having to remember anything. If a hospital procedure is the only thing that's available, that is also not the right option for a bunch of women. And if the only thing that's available is miso[prostol] at home without any support, that

may not be the right thing either." This physician acknowledges the ideal is always an individualized decision, based on the circumstances that an individual may find themselves in at a particular time. In other words, the choice of method is always a personal decision best made by the person terminating the pregnancy, not by the expert or anyone else. After outlining their values and their ideal scenario of abortion provision, many respondents realized that their ideals for abortion provision could align with SSMA.

Evolving Views of SSMA

In the section above, we describe the challenges of relinquishing control of medication abortion despite the evidence of its safety and efficacy. We also describe physicians who were able to incorporate a new model into their paradigm of abortion care. Physicians did so through carefully reflecting on their values and challenging their normative perspectives on SSMA. In the previous work resulting from this study (Karlin et al. 2021), we reported that half of the baseline cohort was fully supportive of the expansion of SMMA, and half were ambivalent, mirroring findings of other researchers (Kerestes et al. 2021). When we compared the mean difference in Likert scale survey responses and performed comparative narrative analysis of the interviews, we did not find that responses were influenced by specialty, years out of training (>10 or <10 years), or gender. The only significant influence on responses was associated with whether someone worked in a more or less restrictive state.

Our comparative analysis of baseline surveys/interviews and follow-up surveys/interviews a year later, however, shows evolving views of SSMA. In the follow-up interviews, physicians attributed this change in perspective to their exposure to additional evidence and to the shifting protocols they experienced that demedicalized medication abortion during the COVID-19 pandemic (Karlin et al. 2020). Many sociologists of medicine have remarked that doctors learn from personal experience, so this is perhaps not surprising (Bosk 2003). What may be more interesting is that many of the respondents reported during their follow-up interviews that the experience of the first interview itself led them to view SSMA more positively. Once the participants had a chance to outline their values and reflect on whether their values aligned with SSMA, they were willing to change their commitment to traditional models of care and embrace SSMA for its potential to strengthen patient empowerment and autonomy.

For example, one physician attributed her shift to a more positive view of SSMA because of published research by the well-respected health research organization Gynuity (Murtagh et al. 2018), which tested the medication abortion drugs available on various websites. Before this study, there had been concerns that the medications purchased online were fake or expired, but this study confirmed their reliability for this participant; as they explained, "I'm more confident in the medicines patients are ordering. I really had a negative view and had worried about [the drugs] not working and safety." Another participant reported feeling more confident about SSMA because of the experience of her clinic's changed protocols during the COVID-19 pandemic, to minimize patient-provider contact. As with many clinics during the pandemic, her facility followed experts' recommendations to dispense with the ultrasound and the follow-up visit that had been parts of the medication abortion protocol. The clinic changed its practice to offer patients an at-home pregnancy test to ascertain whether the abortion had been complete, in accordance with newly published recommendations (Raymond et al. 2018). As this respondent reported, "We [now] are really doing pretty much no-touch abortions. We're trusting that women know their last period, and we either have them drive up and pick up their meds or we put them in the mail to them. And it really has just made me more thoughtful about the whole process and how it really is okay for women to be more independent about it. I think last time we talked, I was worried about people not having the emotional support that they need or not getting quality meds if they just did online . . . and I am still worried about that, but now I'm much more comfortable with this new process and a whole lot more comfortable with giving women that flexibility and kind of giving them back that power."

Not only did the direct experience with new evidence and protocols change physician views, but the interview process itself—and, more specifically, the act of evaluating ones' values and actions—also influenced these evolving views. As one participant from the Northeast explained in a follow-up interview: "It's funny because we got off the phone and I was like, 'Wow, am I part of the patriarchy?' It really got me thinking about the way I looked at it. . . . [When you] asked me about self-administered abortions without any kind of medical involvement, I [thought], 'Oh no, we can't have people doing that.' . . . And we finished our conversation and then I got off the phone and I thought, 'Wait a minute, why not?' It just really opened my eyes since you know, my own—not judgment, but my own values and my own fears probably—it was my own stuff. I really think that's what it was." Still another physician explained, "This discussion

helped me really go back to what my values are and what my core beliefs are about abortion care, and if you truly can say that you believe in patient autonomy and access, it's not a big step to say, 'Yeah, self-managed abortion lines up with those.' And then I just explored a little bit about what makes me uncomfortable and how much of that is about me, and how much of that is true, and how much of that lines up with not trusting patients to make decisions, which isn't something that I'm comfortable with."

This shift in attitude from placing the power and control that are often in medical professionals' hands into the hands of laypeople is not an easy change and can be uncomfortable for some doctors. As an ob-gyn from the Midwest described it, "I think there's always going to be some discomfort on the physician's part. But that is okay. I didn't used to be so good about discomfort. Maybe it just is getting older or having thought more about things, or just having had lots more experience, that my discomfort is okay? We shouldn't expect to feel comfortable all the time. So, I think like with anything, remaining flexible is a really important life skill. . . . All I can do is operate from my experience, which isn't always accurate. And so I think just being open to learning and open to change is really important in medicine, but also just in life in general." Still another physician explained, "I feel like our first conversation around self-managed abortion sparked more of my own work and understanding the barriers that we're putting up. And the concerns that *we* have [emphasis added]. And so, I feel like over the past year or so, I've done more reading and l paid attention to this more. And so, I feel pretty supportive of it." These participants all acknowledge that their mental model changed not just through gaining medical knowledge and evidence but also through an active process of reflecting on their values and then critically assessing their practices in relationship to their values. We suggest that these providers may be more open to this kind of questioning of norms as a result of their experiences of marginalization in the medical community as well as the delegitimization they have experienced in the public sphere.

The Future of SSMA

When we asked specifically about what it would take for the demedicalization of medication abortion to become a reality, participants responded that changing the culture of medicine was needed. Most felt that the evidence for the safety and efficacy of medication abortion without tests was sufficient, while noting that the research lacked data about satisfaction of patients who self-sourced their pills (although since these interviews, data has been published supporting patient satisfaction; see Madera et al. 2022).

Even when we asked if additional tests for determining gestational age would be helpful, most participants said that they trusted the evidence that most patients could assess their gestational age well, even if their personal experience did not always reflect this. To change the culture of medicine, participants noted the importance of disseminating high-quality research to all stakeholders, including providers, patients, community members, and legislators in support of SSMA. They also thought that providers had a responsibility to advocate for the decriminalization of abortion generally (and of self-managed abortion specifically) and to encourage support among clinicians, pro-choice advocacy groups, and professional medical organizations. In this way, our respondents acknowledged that acceptance of SSMA was not about medical evidence nor about their expertise or producing more medical data, but about political and social advocacy.

Three participants felt that demedicalization was never going to happen because of their experiences of barriers to medications abortion, the current restrictive state of abortion laws in America, and the lack of support from professional organizations and funders. As a family doctor from a restrictive state in the Midwest stated, "[Legal SSMA] just seems so far away. We just passed the heartbeat bill here. We're not there. We're never going to get there." The fact that the only demographic characteristic influencing support of SSMA was if a respondent was from an abortion-hostile state or an abortion-friendly state reflects how much political climate and fear of retaliation affect perspectives on medically safe practices.

We noted how physicians understood their professional identity and values compared to how they viewed their general physician colleagues when we asked participants about frameworks that would support SSMA. They suggested that they likely valued patient autonomy more than their nonabortion physician colleagues, and they hypothesized that this predilection may be why they were willing to question standards of care more readily. When we provided potential frameworks and asked about additional ones that might best describe SSMA, most participants liked the language of empowerment for self-care best and suggested that this concept supported patient autonomy and capacity the most. A Midwest ob-gyn defined self-care as follows: "It makes a statement that women are smart and educated and they're going to make the right choice and they're going to make themselves safe. And we [must] offer them the resources and the options to do that." While participants stated that they preferred the language of self-care and the values inherent in the concept, most respondents acknowledged that such a narrative would likely not be persuasive to medical colleagues, as they worried the concept sounded too "New Agey" and that a reorientation of medicine toward self-care was not imminent.

When asked about their colleagues' views on self-care, a family doctor in one of the most antiabortion states explained: "I think that we're a pretty medicalized community, and we have some overlap with advocacy work and community work. But most of the stuff that we're doing—like so many of us are researchers and clinicians—we're pretty focused in our insular medical world." These abortion providers recognize their professional identity as distinct from the general medical community, which they perceived as biased toward more conventional views of physician authority.

Participants also felt that the "person-centered or patient-centered care" framework aligned well with SSMA, particularly around supporting autonomy and ensuring that individuals have access to all options, including demedicalized abortions. A physician from New England mused, "I think it is probably the epitome of person-centered care, right? Allowing people to do what most fits their family and lifestyle and value system." In fact, a large portion of participants selected this framework as the one that might resonate the most with other providers (n = 15). However, a few participants expressed concerns that patient-centered care would be unappealing to fellow abortion doctors who question SSMA's efficacy (or patients' health literacy) as well as overlooking people who are forced to self-manage out of necessity. Not only do most of these providers state that patient-centered care is one of their main values when providing abortion and general care, they also use the narrative of patient-centered care to explain their support of SSMA. This may seem ironic given that these doctors are using a term conceptualized for the health care setting to describe a process that takes place outside that setting, but their use of this term in this context can be understood as their strong endorsement of letting patients determine their preferred treatment. Moreover, a narrative of patient-centered care to describe SSMA highlights participants' belief that they and their abortion colleagues have embraced this approach to patient care more readily than their nonabortion physician colleagues.

Conclusion: The "New" Abortion Provider

The fact that half of the 40 abortion providers interviewed for this study support the concept of SSMA, while most of the remainder are at least ambivalent and only a few are strictly opposed, is a striking finding. Certainly, this goes against conventional understandings of professional authority in medicine. It is true that the purest notions of "professional dominance" of physicians and their prerogative to control the terms of medical practice, articulated by medical sociologists in the past (Freidson 2006; Hughes 1971), have been mitigated over the years by such

factors as the corporatization of medicine and the decline of private practice (Abbott 2014). Nonetheless, half of this cohort of abortion doctors appear to be outliers compared to most US physicians in their willingness to give up their gatekeeper role. To fully grasp the generational (and ideological) change this represents, recall the complaint quoted at the start of this article from the physician at the 1970 AMA meeting who, in voicing his discomfort with legal abortion, said, "Legal abortion makes the patient truly the physician: she makes the diagnosis and established the therapy." To this, it appears a substantial portion of our respondents would approvingly reply, "Exactly!" At this moment in time, these physicians feel as if they are not meeting their professional responsibilities if they are not more responsive to people's desires to receive the kind of care they want, where and how they want it. Although these doctors are cognizant of the longstanding struggles we recounted earlier of the first generation of legal abortion providers to normalize abortion care within mainstream medical institutions, physicians today have the opportunity to reevaluate their place in abortion care, because medication abortion—which was not available to the earlier generation of providers—has proven to be safe, effective, and desirable for suitable candidates outside the clinical setting.

So how does this group's acceptance of the demedicalization of abortion reconcile with the abovementioned earlier efforts of pro-choice physicians to promote abortion as part of normal reproductive health care within medical institutions? Admittedly, this reconciliation is complex. These contemporary physicians recognize that the legitimacy of abortion within mainstream health care has been an issue since the time of *Roe v Wade*. But for them, SSMA offers the other side of this legitimacy paradox. If one way to manage the stigma of abortion care is to claim expertise, the other way to address this paradox is to normalize abortion provision by changing the kind of knowledge the practice requires—that is, to promote SSMA as accessible and safe self-care.

This endorsement of SSMA, however, does not come without ambivalence. As we have shown, contact with patients is a deeply satisfying aspect of abortion provision for those interviewed, and they acknowledge the significant trade-off involved when they give this up. These providers favoring SSMA are very aware of the challenges of getting their medical colleagues on board—both other abortion providers as well as other health care professionals who might be interacting with SSMA patients, particularly emergency room personnel. As we noted, those interviewed in abortion-hostile states are considerably more dubious about their colleagues' acceptance of SSMA.

According to the participants in this study, the messaging to get clinicians on board with SSMA must include the narrative of person-centered care. This implies situations in which people can choose from a spectrum of options for terminating their pregnancies, including obtaining the medications on their own and either following internet-based instructions or consulting with providers on how to use these drugs; gaining access to the drugs through telemedicine or in a clinic; or opting for a clinic-based procedure. Because medication abortion is typically used in the United States only through the 10th or 11th week of pregnancy, there will obviously continue to be a need for clinic or hospital-based abortions for individuals past that gestational age, or for those who are not suitable candidates for a medication abortion.

The limitations of this study include not sampling other types of providers, such as advanced practice clinicians who provide safe and effective abortion care (Weitz et al. 2013). In addition to including these members of the abortion workforce, future research would include clinicians who do not provide abortions, to understand how clinicians not directly involved in abortion work understand changing norms around abortion . This information would be very important because fewer than a quarter of ob-gyns have provided abortion care in the last year, and even fewer PCPs perform abortion care, even though it is clearly within their scope of practice (Grossman et al. 2019; Yanow 2013). Given that clinicians who do not provide abortions see most of the reproductive-age people in the United States, it is essential to recognize their understanding of SSMA as this practice increases.

As this article has shown, the crisis of abortion in the United States has compelled physicians who provide abortion care to reexamine their values and question the norms of medical expertise. We suggest that our informants were led to do this professional and personal soul-searching as a result of the highly politicized nature of their work. However, it is quite possible that we are pointing toward a more general trend, among a subset of contemporary "social justice" physicians, of questioning who benefits from control and expertise within the profession of medicine. Certainly, the change in our informants' perspectives after they struggled with the tensions in their value systems speaks to the importance of reflective work and values clarification in medical professionalism.

With regard to the future landscape of abortion care in the United States, in the post-*Roe* era SSMA will clearly become even more widely utilized. Data has shown that as limitations to in-clinic abortion increase, so too do efforts to secure self-sourced medications to manage an abortion (Aiken

et al. 2020). The extent to which abortion providers, such as those discussed in this article, will be involved in this phenomenon remains to be seen, as do the legal ramifications of this involvement. We speculate that some portion of current abortion providers will, like earlier generations, play a prominent role in facilitating abortion access despite the difficult landscape created by *Dobbs*. These caregivers have taken an oath to "do no harm" and have done the difficult work of assessing the evidence base for this practice, confirming its safety and efficacy, and resolving contradictions in their own values so they can wholeheartedly support the reproductive autonomy of all individuals. We recognize their diligent work and commend the position of medical organizations that have correspondingly called for the decriminalization of SSMA, such as the American College of Obstetricians and Gynecologists (ACOG 2017). We further suggest that this demand be afforded both to individuals terminating their pregnancies and to those who help them. We end by calling on all physicians and public health colleagues to follow these participants' and professional organizations' lead to interrogate their own values around patient autonomy and person-centered care. In doing so, we may find the principles the medical profession holds most dear at this historical moment may be in alignment with SMMA and other practices of demedicalization.

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