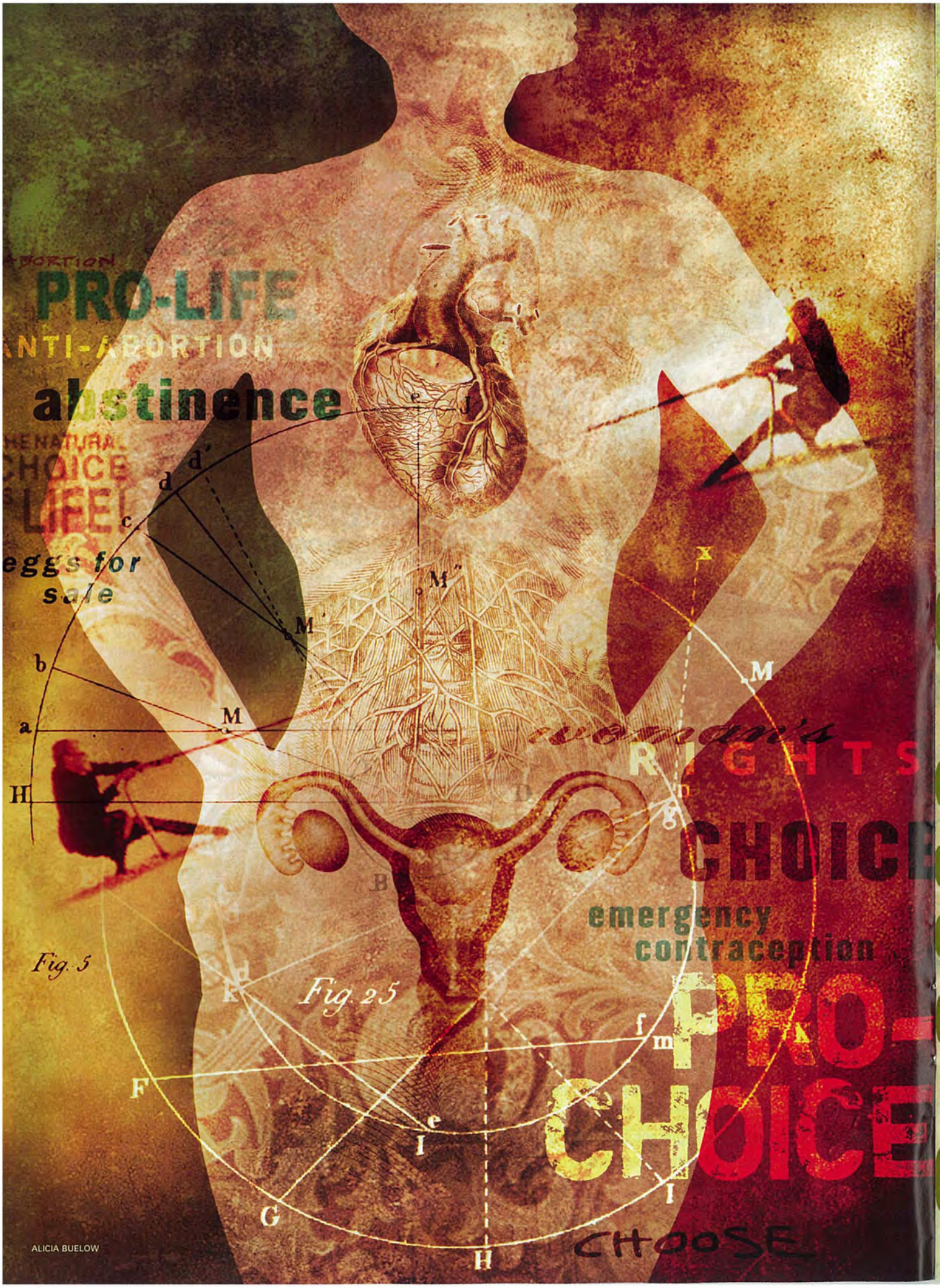
PRO-LIFE
ANTI-ABORTION
abstinence
eggs for sale
women's
RIGHTS
CHOICE
emergency contraception
PRO-CHOICE
CHOOSE
Fig. 5
Fig. 25
ALICIA BUELOW

"The Absolute Mistress of Her Body"

A century after Sanger, women's reproductive health still inflames partisan passions

In 1916, Margaret Sanger opened the first family planning and birth control clinic in the United States. It was raided by police several days later, and Sanger served 30 days in prison for disseminating information about birth control, one of many arrests and imprisonments as she attempted to educate poor women about limiting their family sizes.

Almost 100 years later, debates about whether a woman is "the absolute mistress of her own body"—as Sanger advocated—continue to fire up opposing sides of medical and social policy. From teaching sex education in schools to funding abstinence-only programs in the battle against AIDS, the issues keep rising up in new and complex ways. In one form or another, reproductive health continues to escape the clinic and turn up in the legislature, debate forums and, often, the streets. Among the latest hotly contested issues are questions about making the new human papilloma virus (HPV) vaccine mandatory for middle-school attendance, offering emergency contraception over the counter, teaching medical students how to perform abortions, and donating one's eggs for medical research or for fertility patients. This month, *The New Physician* takes a closer look at these four issues from both sides. →

BY AVERY HURT

If it lives up to expectations, the vaccine against HPV, recently approved for use in girls and women from 9 to 26 years old, may one day be considered among the great advances in medicine—and certainly a much-needed win in the war on cancer. Infection with HPV is a condition for developing cervical cancer, which kills almost 4,000 women each year in the United States alone.

Widespread use of the vaccine, marketed by Merck & Co. Inc. under the brand name Gardisil, would eliminate as much as 70 percent of cervical cancer and almost all cases of genital warts, experts believe. The vaccine appears to be both harmless and effective.

A no-brainer? Well, not exactly.

The HPV vaccine boasts an impressive list of "firsts." It is the first vaccine primarily intended to prevent cancer, the first to target a single gender (though boys may soon be getting it as well) and the first approved for use in children to prevent a sexually transmitted disease (STD). If some advocates get their way, it will be added to the list of vaccines required for school attendance.

Because the drug is effective only before infection, the vaccine must be received before a girl becomes sexually active, hence its recommendation for preteens. And as with all vaccines intended to wipe out a disease, the public-health benefits will only be realized if it is widely used, so mandatory vaccination is being pushed in some state legislatures.

Although consensus among both liberals and conservatives is that the vaccine is a great medical advance, not everyone agrees that it is great for children. Conservative organizations such as Focus on the Family and the Family Research Council initially focused their opposition to vaccinating children on the argument that a drug to prevent STDs would encourage promiscuity and interfere with messages promoting abstinence before marriage and faithfulness within marriage.

But now that the vaccine is available, and states like Michigan and Illinois are considering legislation making it mandatory for girls entering middle school, opposition arguments have subtly shifted. Pro-family groups are now resisting efforts underway to require the vaccine for school attendance. "Governments should interfere with parental rights as little as possible," says Linda Klepacki, sexual health analyst for Focus on the Family.

However, the group's resistance to government-mandated vaccination does not extend to measles, chickenpox and other routine vaccines. "The behavior associated with this virus makes it a different issue," explains Klepacki. "You can't get HPV while sitting in a classroom doing math." She says that the organization struggled with the issue because of the obvious public-health benefits, but ultimately decided that as long as there was another way to prevent the disease (abstinence), the vaccine should not be required for school.

Widespread inoculation is not the only reason for making the vaccination mandatory. Dr. Katherine O'Connell, assistant clinical professor of OB-Gyn at Columbia University College of Physicians and Surgeons and a member of Physicians for Reproductive Health and Choice, points out that the HPV vaccine is not cheap. According to the Centers for Disease Control and Prevention (CDC), a full series of HPV vaccinations costs $360. If the CDC advisory committee on immunization practices recommends that it be included with other routine childhood immunizations, insurance companies are likely to cover the cost. This could make a big difference in the public-health benefit of the vaccine.

Despite much press attention on the concerns of abstinence-only groups, resistance to mandatory vaccination seems to be relatively weak and getting weaker. Even opponents agree that when properly informed about the risks and benefits of vaccination, most parents will choose to have their children vaccinated.

"My inclination is to say that the treatment of and elimination of disease takes precedence over concerns [about promiscuity]," says Stanford University premed George Capps, who serves as vice president and publicity officer for the university's Students for Life group, but whose opinion, he adds, does not necessarily represent that of the organization. David Mayans, a politically conservative third-year at the University of Kansas (KU) School of Medicine, agrees: "It would be silly not to get a vaccine that could prevent cancer. If people know the facts, they'll get the vaccine. That's why education is crucial, and I don't think the HPV vaccine has been explained well."

PILLS: OFFICE OF POPULATION RESEARCH AT PRINCETON UNIVERSITY

Over-the-counter (OTC) sales of emergency contraception, or Plan B as its manufacturers have named it, has been a contentious issue for many years now. In April 2003, Barr Laboratories applied to the Food and Drug Administration (FDA) to get its product approved for OTC sales, citing the drug's safety and estimations that faster and easier access to Plan B would reduce the rate of unintended pregnancy by 50 percent and the number of abortions by 500,000 per year. Whether or not these last two claims are credible, a review of the safety and efficacy of the drug convinced 23 of 27 members of the combined FDA Over-the-Counter

The most serious opposition to OTC sales of Plan B comes from pro-life supporters who see the drug as an abortifacient.

and Reproductive Health Drugs advisory committees to approve the drug for OTC sales.

Despite this overwhelming endorsement by its advisory committees, the FDA did not approve Plan B for OTC sales for three more years, prompting claims that the FDA based its decision on political expediency rather than scientific evidence. This prompted the resignation in August 2005 of Susan Wood as FDA assistant commissioner for Women's Health. A few months later, Dr. Frank Davidoff, editor emeritus of the *Annals of Internal Medicine*, resigned from his post on the FDA's Nonprescription Drug Advisory Committee for the same reasons.

Problems with offering Plan B OTC touch on several issues. Concerns that easy access causes an increase in STDs (because women might use it in place of barrier methods) is supported in one or two small studies, but there is not really enough evidence to make this a serious concern, says Davidoff. Claims that easy access to Plan B has not lowered the rate of abortions in countries where it is already available are also weakened by lack of evidence. "Even in countries where [emergency contraception] is already available OTC, the usage rate is too low to tell if it will lower the rate of abortions," explains Davidoff.

Some have suggested that even though Plan B is safe when used as directed, it has the potential for abuse. If women use it too often in place of other contraceptive measures, they might risk health problems from the large doses of progestin in the pills. "Plan B is just a very high-dose birth control pill," says Dr. Jane Orient, executive director of the politically conservative Association of American Physicians and Surgeons. "And hormones have side effects."

O'Connell counters by pointing out that Plan B contains progestin only, and most of the health-damaging side effects of birth control pills result from estrogen. Progestin, says O'Connell, causes only "nuisance" symptoms—nausea, bleeding and disruption of the regular menstrual cycle. Davidoff asserts that the drug is not likely to be abused, first because of these mild but unpleasant side effects, and second, the cost will prohibit most from using Plan B as a routine form of birth control.

The most serious opposition to OTC sales of Plan B comes from pro-life supporters who see the drug as an abortifacient. In rare cases, the drug may prevent pregnancy by interfering with implantation after fertilization has occurred, but most medical experts who have reviewed the data on Plan B say that this is extremely unlikely when the pill is taken as directed—within 72 hours of unprotected sex. "We can't absolutely rule out that Plan B interferes with implantation, but it is not very likely," says Davidoff.

But that slim possibility is enough for many of Plan B's detractors. Like many pro-life activists, Jill Onesti, a third-year at KU School of Medicine, believes that life begins at conception, not implantation.

"The ideal [contraceptive] agent would be one that prevents conception while not placing an already formed life at any increased risk. I am not convinced that we have found a method to prevent fertilization without risking the embryo," she says.

Debate about abortion often centers on the question of overturning *Roe v. Wade*, the Supreme Court case that established the right to an elective abortion. Meanwhile, other attempts to limit abortion have been successful in more indirect ways. Even when abortion rights are constitutionally protected, the procedure can be effectively denied to many women when clinics that provide the service are rare and distant, and few doctors are willing and trained to perform the procedure.

Currently, only about 12 percent of U.S. OB-Gyn residency programs require training for first-trimester abortions, according to the group Medical Students for Choice. In addition, only 7 percent of abortions are done in hospitals, and that's where the residents do most of their training. Suzanne Poppema, co-vice chair of Physicians for Reproductive Health and Choice and a retired clinical associate professor of medicine at the University of Washington School of Medicine, points out that even when abortions are done in a hospital setting, they are typically done with general anesthesia and aren't really anything like the elective procedure performed in most outpatient clinics. Students who want to learn the procedure have to seek their own clerkships or other opportunities to learn. It takes a great deal of motivation, time and effort for most students to get this kind of training, she says.

According to the National Abortion Federation, the number of abortion providers in the United States has decreased by 37 percent since 1982.

And many of the doctors who are still performing abortions are getting older. If there are no new doctors qualified to take their place, soon there may be too few qualified abortion providers to meet the demand, even if the procedure remains legal.

And abortion *is* in demand. It remains one of the most common surgical procedures performed on women, and according to the Guttmacher Institute, 40 percent of American women have at least one during their reproductive years. Controversial it may be, but unpopular it is not.

So why don't medical schools make

more of an effort to train their students in this very common procedure? The reason is fear, says Poppema, who spent her OB-Gyn career performing abortions alongside her other duties. "Universities are loathe to teach abortion because it is controversial," she says. "They are afraid that potential donors won't give their school money if they teach abortion." Poppema knows about the effect a climate of fear can have on abortion access. After 15 years troubled by nothing more serious than occasional protestors, she was unable to renew the lease on her clinic in 2002 because the owners were worried about violence. "Once again, politics has trumped science," she says.

University administrators may be fearful of the ramifications of providing abortion training, but not all who are committed to the pro-life cause hold such all-or-nothing views. Capps of Stanford Students for Life has this to say: "If I had my way, no one would have the option to learn how to perform abortions, but, if an abortion is going to occur, it is admittedly better for it to be carried out by a trained professional as 'safely'—for the mother, if certainly not for the baby—as possible. I may protest the medical status afforded abortion, but, given that it currently has such a status, I am not going to go out of my way to protest the fact that medical students have the option to learn it."

In 1995, the Accreditation Council for Graduate Medical Education (ACGME) attempted to address the problem by requiring OB-Gyn residency programs to provide routine abortion training. The requirement made a distinction between treating spontaneous abortion (miscarriage) and inducing abortion.

Although residency programs are required to provide training in spontaneous abortion, they are required only to "provide access to experience" in induced abortion, and the training does not have to be on site. The mandate does not require students to actually perform abortions, so residents with moral or religious objections are free to opt out of the training.

According to many, this distinction takes the teeth out of the ACGME mandate. Erin Cox, a fourth-year at Albert Einstein College of Medicine who is applying to OB-Gyn residency programs, is attending medical school on a military scholarship. "I have done some OB-Gyn rotations at military hospitals where abortions are not offered because it is illegal to use federal funding to pay for abortions. I think it is horrific that OB-Gyns are trained in locations where abortions are not done," she says.

In 1996, Congress countered the ACGME's requirement by passing the Coats Amendment, so residency programs that do not offer induced-abortion training will still be considered accredited by the federal government and thus still eligible for federal funds.

Many institutions, Catholic hospitals in particular, welcomed the amendment, but still have problems with the ACGME mandate. Since it is out of the question for Catholic hospitals to provide abortions, they are in a bit of a bind when it comes to complying with the regulation requiring them to provide the training to students who want it. According to the Catholic organization National Committee for a Human Life Amendment, having to farm out portions of their training could damage their competitiveness with other institutions as well as cause them to be seen as practicing "substandard" medicine.

Marie Hilliard, director of bioethics and public policy at the National Catholic Bioethics Center, agrees that the requirements place a burden on institutions that have moral or religious objections to abortion. She is also concerned with the provision in the ACGME's statement that public teaching hospitals must provide abortion training, since, in keeping with the principle of separation of church and state, public institutions could come under fire for allowing students to opt out on religious grounds. "The First Amendment says that there shall be no state religion, but it also protects free expression of religion," says Hilliard. While she notes that the ACGME requirements offer opportunities for both individuals and programs to opt out, "[The ACGME requirement] is another example of the creeping infringement on religious liberties," she says.

The drug RU-486, also known as "the abortion pill" and sold under the trade name Mifeprex in the United States, may come to the rescue, although it is only effective within the first 63 days after the first missed period, creating many of the same barriers as a lack of local clinics. Cox points out that most patients, when given the choice between a traditional abortion and RU-486, choose the traditional method. Although taking a series of pills seems easier than having a surgical procedure, "Most people just want to get it over with and go home," says Cox.

As one expert put it, egg donation opponents make for strange bedfellows. Most of the controversial issues surrounding reproductive health fall into clear and usual patterns. The right lines up behind their causes, and the left lines up behind theirs. But when it comes to egg donation, it can be more difficult to make partisan distinctions. The religious right tends to oppose egg donation for the purposes of medical research for much the same reason it opposes emergency contraception: fertilized eggs—thus potential human lives—may be destroyed.

Many on the right oppose donating eggs to infertile women as well. The Catholic faith opposes any kind of artificial conception, and some Protestant groups oppose reproductive technology because they believe it weakens the traditional family.

But opposition to paying young women for their eggs—no matter what the eventual use of those eggs will be—can be found on both sides of the political divide. Soliciting young women to donate eggs exploits women, opponents say, no matter what they think of the other issues surrounding the practice.

Despite the fact that these women are called egg "donors," virtually all are paid, sometimes very large amounts. The clinics that seek donors have been accused of preying on young women who need cash—often college students with mounting educational expenses. People who are seeking eggs to become pregnant are particularly eager to get the ova of bright, attractive Ivy League students—students who may be facing tremendous educational debts.

When eggs are purchased under these circumstances, it can be difficult to give truly informed consent for the procedure, critics say. "Dangling large sums of money in front of people's noses can make them less likely to consider the dangers of the procedure in question," says Bonnie Steinbock, professor of philosophy at the University of Albany and author of several papers on egg donation and related topics.

On top of that, it is not clear that donors are accurately informed of the risks. Jennifer Lahl, national director for the Center for Bioethics and Culture Network, doesn't believe that informed consent is ever possible, whether the donors are being paid or not. "Women can't give informed consent because we don't have adequate information to give them. No long-term studies have been done on the risks of repeated use of the drugs that are used [to stimulate egg production in donors]," says Lahl.

Steinbock also points out that when children are produced in this way, the court system often has to deal with ethical problems years later. Court cases concerning divorced couples fighting over who gets custody of embryos in storage and fathers who deny parentage of children produced by artificial insemination may be just a preview of things to come for courts wading their way through this new territory.

In an attempt to alleviate at least a few of these concerns, many legislatures are considering bills that would cap payments for egg donations. In September, a law was passed in California prohibiting scientists from paying egg donors any more than is necessary to reimburse them for their expenses. The law also increases the requirements for informed consent, but they apply only to eggs donated for medical research and do not address donors to fertility clinics.

It will likely take many years before clear regulations are formed on this issue. Meanwhile, perhaps, the strange bedfellows can work on some compromises in other contentious areas of women's reproductive health.

The New Physician *contributing editor Avery Hurt is a freelance writer based in Birmingham, Alabama.*

HAVE ANY COMMENTS ABOUT THIS TOPIC? WE WANT TO HEAR FROM YOU: E-MAIL TNP@AMSA.ORG.