CHOICE /LESS

Rewire Radio

Dr. Debra Stulberg:
Did you hear we're going to be working for the Pope?

Debra Stulberg: In our health-care system at large we have gotten to a place where for the most part abortion is segregated from mainstream medical care.

I think if women choose [abortion], they should be able to get their abortion care where they get the rest of their care. We know that at least first-trimester abortion is extremely safe. It can be done in an outpatient setting with very few complications, at very low risk to women. And it's not, not because of any medical reason. It's not provided in primary-care offices and in many OBGYN offices purely because of the stigma and because institutions, Catholic and otherwise, would rather somebody else deal with it.

Jenn Stanley: This is CHOICE/LESS, a storytelling podcast from Rewire Radio about reproductive injustice and the laws that put people in choice-less situations. I'm Jenn Stanley, senior staff reporter at Rewire, and the host of this podcast.

This is the last episode of season one. We'll be taking a break to record more stories and we'll be back in the winter.

This season, I've spoken to women across the country who've faced barriers to accessing birth control, abortion, and prenatal care. We've explored the real life, and at times devastating, ramifications of anti-choice policies, and discussed how even when these laws are struck down, the damage done is often beyond repair.

Why is abortion, more often than not, sequestered from other health care? Even in states that haven't passed much anti-choice legislation, most people seeking abortions will have to walk through crowds of protesters and prayer circles yelling and flashing graphic photos at them.

I'll be real with you, if I were going to a health clinic for a colonoscopy, which is statistically riskier than abortion, I'd be pretty annoyed, and maybe even a little traumatized, if a group of people blocked the entryway, showing me photos of anuses and the insides of a human digestive track. Let's face it, medical procedures can be ugly. But keeping reproductive health care separate from other health care is a way to shame and control the bodies women, trans, and gender nonconforming people.

One thing that we haven't talked much about this season is how anti-choice organizations, activists, and lawmakers use freedom of speech and freedom of religion to deny access and further segregate and stigmatize birth control and abortion care.

Today we hear from Dr. Debra Stulberg, who became a family physician and abortion provider in an attempt to provide full-spectrum health care to underserved communities.

But during her residency, she saw the dark side of so-called religious freedom, and the effect that it can have on quality of care. Here's her story.

DS: I did not go to college thinking that I wanted to be a doctor. I knew growing up in Chicago, and specifically in Hyde Park on the South Side of of Chicago, that I knew I was really interested in issues around urban poverty and how families cope and try to thrive in that setting. I had done quite a bit of tutoring and other types of volunteering on the South Side of Chicago. I thought I would be a social worker, teacher, or psychologist, working with families living in urban poverty.

It was in that setting that the idea of medicine as a means to that end first really appealed to me.

I went to Harvard for college, and I was working in an after-school program through the Phillips Brooks House, working in one of the housing projects in Boston. And the kids I was working with were 10 and 11 years old and mostly girls. And a couple of the girls I had gotten close with were talking among themselves and talking with us, their college student tutors, about their older sisters and cousins who were having babies in high school. And we listened to these girls talk and it was clear that at 10 and 11, a lot of these kids anticipated that that was their only future, that was their only path, that they would have kids. They were having conversations about if they wanted to wait until they got out of high school to have their first baby. This was such a different life experience for me. I saw these kids as really smart and having lots of great ideas, and the idea to me that early motherhood was the only option they could see just was really striking and kind of upsetting to me.

So I started thinking about the role of an adolescent medicine doctor or an OBGYN working in a community health center as someone who could really make a difference and get to know teenagers and provide options, help them access options for their lives maybe other than becoming parents really young.

The first step was taking a lot of science classes that I avoided. I was a women's studies major studying policy around a lot of these issues. So first I had to go and make sure than I was OK taking chemistry and biology. When I figured out that I could basically make it through those I decided to go ahead and apply to medical school. I had to go back and take a whole bunch of science classes and then ended up going back to Boston and back to Harvard for med school.

I was able to do a little more work in that same community. And the piece that really changed for me during medical school was finding family medicine. I went in thinking OBGYN was the path you take if you want to provide women's health and focus on reproductive health. Through a couple wonderful mentors in the Boston area and around the country I learned that family physicians really can be full scope reproductive health care providers.

I knew going in to medical school that I wanted to be an abortion provider. I wanted to include abortion as one of the services that I offered because I felt that it was really important and it's something women don't have the access to that they deserve. So the discovery that family physicians can be abortion providers, that there are many family physicians who are abortion providers, and in sort of a holistic context where you're seeing a person within their family, within their community, was really appealing to me. And that's what I love about the field of family medicine, and that's a great choice for me.

JS: Dr. Stulberg was actively involved in Medical Students for Choice, and though she was aware of the prevalence of clinic violence while she was in medical school in the late nineties, early aughts, she says the overall culture at Harvard Medical School was supportive of her decision to become an abortion provider.

DS: When I finished med school I made the decision to come home to Chicago where I had grown up to do my residency. At the time, there was not a single family medicine residency in the Chicago area that offered abortion training as a routine part of the curriculum. There were programs that expressed support and people told me during the interview process that there would be opportunities for me to get that training, so I decided to pick a hospital that told me I had a lot of elective time I could use and they expressed support for me using my elective time to get abortion training.

That turned out to be more difficult than I thought for a couple reasons. I chose West Suburban hospital for my residency and West Suburban is a really interesting place. It sits just on the suburban side of the western edge of the city of Chicago. The hospital literally sits on Austin Boulevard, and on the east side of Austin Boulevard is the neighborhood of Austin on the West Side of Chicago and on the other side is the suburb of Oak Park.

West Suburban hospital has a really strong commitment to providing high-quality care to the underserved community on the West Side of Chicago. They also are known within the family medicine world with a very strong training program in women's health, and especially in obstetrics and maternal and child health. And they take a public health approach to a lot of those issues.

At the time they also expressed support for my getting abortion training and told me that other people had gone through that. It turned out to be more challenging for me to get abortion training than I expected for a number of reasons. One is that the clinics around the Chicago area at the time were really not set up to take residents, and I didn't know that at the time. I ended up having to call around a lot and use a lot of my contacts from Medical Students for Choice. Even so, in order to get the training that I felt I needed I had to spend a month and a half in New York, and I was able to get in for one month at Planned Parenthood.

The other thing that happened during my residency is that West Suburban Hospital announced that it was going to be taken over by Resurrection Health Care, a large Catholic hospital system.

I learned this while I was on call one night. The attending physician who I was working with and I ran off the labor and delivery floor to grab a quick dinner. We were sitting in the cafeteria and he said to me, "Did you hear we're going to be working for the Pope?" And I had no idea what he was talking about, but came to find out that West Suburban was in the final stages of sealing the deal to be acquired by Resurrection.

I was in my first year of a three-year program. Now the first thing that I thought of was how it was going to affect my abortion training that I felt really strongly about. And I should mention that West Suburban was not providing abortion services at the time. So like many people at the time, I thought that the implications for patients would not be that big, because we weren't providing abortions and Catholic hospitals can't do abortions. But as I was driving home the next day, I started thinking about other services we were providing and wondering if those would be impacted.

JS: Refusal laws, also called conscience laws, allow people and institutions such as hospitals, pharmacists, employers, and insurers, to refuse to provide, pay for, or refer for medical treatment. These laws came into play in 1973, after Roe vs. Wade legalized abortion in the United States. And we've seen a resurgence of this kind of legislation in the last decade.

In recent years of turmoil in the health-care industry, non-profit and community hospitals have struggled to stay afloat, while Catholic hospitals have taken over and thrived. And when a nonsectarian hospital merges with a Catholic hospital, it becomes subject to the rules of the Church.

About 20 percent of the hospital beds in the United States are owned by the Catholic Church, according to NARAL Pro-Choice America. And as of 2013, ten of the 25 largest health-care networks in the United States were Catholic, according to a joint report by the American Civil Liberties Union and Merger Watch, a non-profit organization that advocates for scientifically accurate patient care and a patient's beliefs over the religious beliefs of the health-care organization.

DS: I called Susan Yanow who was a friend, colleague, and mentor of mine when I was in medical school, and she said you have to call Merger Watch and that's what I did. I called the organization Merger Watch, and they were and still are really the experts at helping communities that want to resist a Catholic hospital merger or takeover, or limiting the effects of Catholic hospital takeovers and the effects of Catholic and other restrictions on care in general.

We did our best to launch a coalition and a community effort to stop that hospital takeover. We created a group that we called West Suburban Merger Watch. We brought together organizations and people from the community and other groups around Chicago that were concerned. In the end the hospital was taken over by Resurrection.

I think we were able to apply some pressure and get the hospital to make some minor concessions, but I do think that women and others in the community really lost access to services when the hospital became part of Resurrection.

One of the most prominent services that we were providing on a regular basis at West Suburban that we had to stop immediately when we became part of the Catholic system was postpartum tubal ligations, well all tubal ligations. But when women were getting their prenatal care with a doctor at West Suburban or one of the affiliated clinics, it was not uncommon for women who reached their desired family size to say, "After I give birth to this baby, can you tie my tubes?" And that was their plan. They had spoken with their doctor. And then the hospital got taken over by Resurrection, and they go into labor and we can't do their tubal, which was really upsetting.

I have spoken with residents who trained after me. They pointed out that even once West Suburban was no longer under Catholic auspices, there were still many doctors who had trained during its time of being owned by Resurrection, and they never leaned how to do tubal ligations. So now women coming into a hospital that is no longer Catholic are facing a situation where the doctor on call may not have the skills.

JS: It also affected a doctor's ability to prescribe contraceptives if the doctor was employed by Resurrection or had a practice in a building owned by Resurrection.

DS: The rules around that and how it gets applied are not uniform across the board. And you hear a lot of work-arounds for how doctors do that. But certainly it's not as straightforward as if you go see your doctor and they're not in a Catholic facility.

So let me give you some examples: one of the things that West Suburban told us, my program director specifically said that, "well in many cases, a patient who is getting birth control may have a medical reason reason why they want to or need birth control. Maybe they have acne and the birth control pill we know is effective for treating acne. So if your reason for giving it is acne, you can give birth control. You can't give it as a contraceptive, but if it happens to have the side effect of being contraceptive, you can give it."

So that work-around of giving contraceptives for non-contraceptive purposes, wink wink, nudge nudge, we know you patient actually want contraceptives. We'll find some other diagnosis you have that we can say is the reason we're giving it is what we were told to do.

For the residents, even if we were working on the off-site independent clinic, because we were employed by the Catholic hospital, we were told that we were no longer allowed to insert IUDs for example, so we had to either choose to do that under the table, and hope that our program didn't find out about it, or we had to refer our patients to someone else.

JS: The merger changed the protocol for prescribing emergency contraceptives to victims of sexual assault in the ER. In fact, 55 percent of Catholic hospitals will not dispense emergency contraceptives even if a patient comes in after having been raped.

DS: Patients who came into the emergency room at West Suburban after a sexual assault when the hospital was secular, a routine part of the protocol was that they received emergency contraception if it was appropriate, and if they were within the medically effective time period. When the hospital takeover talks were happening one of the things that our Merger Watch group did was try to call attention to the fact that emergency contraception may not be available in the ER. So the hospital at the highest level made a decision that they would follow a protocol that has been used by other Catholic hospitals. It was called the Peoria Protocol after a hospital in Peoria where it was first used.

I believe that says if a woman comes in after a sexual assault, and it is medically appropriate for emergency contraception, we will administer an ovulation test. If it shows she's ovulating, we can't give it because then there's a risk or preventing implantation of a fertilized egg. Now around the time of ovulation is the time that you're most likely to conceive, and therefore the time that the medicine would be most helpful. But they decided they were going to use this protocol, or they could call a doctor from the offsite clinic, and have a procedure for the patient to get a prescription for emergency contraception offsite from another doctor, adding a layer of hassle, need for transportation, etc. for the patient, but that was their work-around for them to be able to publicly say, OK, we can still provide emergency contraception.

JS: And this is really only the beginning. The ambiguity of many Catholic hospitals ethical training regarding how to care for a patient with an ectopic pregnancy or a preterm rupture of the membrane could lead to life-threatening complications.

DS: One case, a woman came in with an ectopic pregnancy, and the doctor who was on call for the obstetric services was consulted. And in her medical opinion the best treatment for this patient was methotrexate which is a medicine you can take for ectopic pregnancy that basically dissolves the pregnancy that's developing in the fallopian tube and allows the woman to have her ectopic pregnancy treated without surgery.

I should say that ectopic pregnancy is life threatening for the pregnant woman. It means that the pregnancy has implanted outside the uterus and 97 percent of them are in the fallopian tube. If the embryo continues to grow in the fallopian tube, the tube can rupture and the woman can hemorrhage and die. Before we had modern treatment for ectopic pregnancy, many, many women died of ectopic pregnancy.

The best thing we can do for it is identify it early and treat it. And in some cases you do need surgery, when it's just not a good candidate for medical treatment with methotrexate. But in this case the doctor felt that methotrexate would be a very good option for the patient. And this doctor had gone through the required training the Catholic ethical and religious directives, and her interpretation from what she had heard was that now that this hospital is Catholic we cannot give methotrexate for ectopic pregnancy. That would be seen as an abortion, and it's not allowed. So she recommended to this patient, if you want methotrexate, which I think is best, you should sign yourself out of this hospital and go to a different hospital where you can get it.

Same thing with rupture of membranes cases. So when the bag of water has broken in a pregnant woman, the risk of an infection setting into the uterus that can spread to her body goes up as time goes on. It's generally thought that if nature has declared itself and the pregnancy is ending, that the sooner the fetus is removed, the safer it is for the woman. That isn't to say that there aren't some times where it's ok to watch and wait for a while but what happened is that a couple of patients came in, their bag of water had broken and the doctor determined the fetus is not viable, and that it's the beginning of a miscarriage. But because the fetus still had a heartbeat, the doctors were told that they could not do anything that would expedite ending the pregnancy, and that they couldn't induce labor. They couldn't do any procedures. In this type of case, the failure to act in a timely fashion when the membranes have ruptured and the fetus is nonviable, are cases that we hear about around the country.

When I learned that the hospital that I had gone to enthusiastically because I thought it was going to be a great place to learn comprehensive women's health was going to become Catholic, I was both very distressed for myself and for my patients, and very motivated to do what I could to fight it. It became the defining experience of my residency, and has gone on to shape a lot of my career.

JS: When she was a resident, Dr. Stulberg was surprised by the lack of data regarding the difference in care at a Catholic facility vs. at a nonsectarian hospital. She and another researcher, Lori Freedman, have devoted their research to learning more about patient and physician perspectives of Catholic health care.

DS: In an effort to get more research on this topic, Lori Freedman and I have started what we called the Research Consortium on Religious Health Care Institutions. Our goal is to provide data and conduct good research, so that policy makers addressing this important issue can do so with good information. We feel that patients should be able to have their own values

expressed in the health care they receive. That health care should be respectful of that, and policy that promotes that needs a good sense of what's so, what is going on currently in religious and secular institutions.

What we're trying to find out is do women even know, first of all how do you identify a Catholic hospital, how do you learn if it is, what its religious affiliation is. And if they know it's Catholic, do they know that means that you shouldn't expect to get a tubal ligation here. You shouldn't expect to get an abortion, even if it's for a severe fetal anomaly or something like that.

When I was a resident, I expected that abortion care would be restricted at a Catholic hospital. I didn't expect that such a broad scope of reproductive health services would be restricted. If other women are like me, I don't think it's fair to put the onus of, oh you can choose to go elsewhere, on women if hospitals aren't being clear in communicating what they do and don't provide.

When you go to your doctor and you say, "Hi I'm here form my checkup, and I'd also like birth control." And they say, "Great let's do your Pap smear, and lets talk about STDs, but if you want birth control, we're going to have to come up with a different reason because I can't do birth control for birth control's sake." That's sending a message that that's not a legitimate medical need. That [birth control] is a separate part of health care or a separate part of your medical needs as a person. Even if you happen to be lucky enough to be able to make it to that next appointment, get the contraceptive you want, go to the other hospital, get the tubal ligation you want, you've been told this need is separate. It's marginal. A I think that's stigmatizing and I think that's part of the harm that further segregates reproductive health care.

JS: Dr. Stulberg has a general primary-care practice at a federally qualified health center that does not provide abortions. She provides at John H. Stroger Hospital of Cook County, a public teaching hospital in Chicago.

DS: So and I teach family medicine residents at UIC who come there for part of their training. So I do provide abortions but I don't provide abortions in an integrated way with my primary care. In general they're separate. They're separate for me as they are for many patients and in our health care system.

Being conscientious about when you have a child, I think is one of the most responsible things a person can do. The ability to have a health-care provider you trust, who can talk to you about your safe and effective options, and help you access the option that you choose, whether that's a contraceptive method or abortion, to me is a right. We should all live in a society where women have the ability to make those choices for themselves, not just on paper but actually have the health care relationships, have access to those services.

I think it should be the opposite of stigmatized. I think it should be celebrated.

JS: We'll be back with new episodes this winter. In the meantime, our podcast feed in iTunes and elsewhere will soon transform from CHOICE/LESS to Rewire Radio. While we prepare new episodes of this show, Rewire will bring you new podcasts and audio stories right here. So stay subscribed and look for a lot more reproductive justice coverage and analysis coming this fall from Rewire Radio.

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