

Providers, pills and power: the US mifepristone abortion trials and caregivers' interpretations of clinical power dynamics

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ABSTRACT In this article, we examine retrospective accounts of health care workers who participated in the Population Council's clinical trials of mifepristone (RU-486) between October 1994 and September 1995. We conducted focus group interviews with 78 health care providers at 17 sites around the USA, after the clinical trials of mifepristone (RU-486) were completed. We discuss providers' reflections upon power dynamics between them and their clients during the clinical trials, as well as the implications of these changes on the future provision of non-surgical abortion. Caregivers tend to see mifepristone users as more 'empowered' than women having surgical abortions, and see themselves as losing power over their clients' abortion experiences. They offer nuanced and ambivalent assessments of the role of empowerment in their clients' motivations and experiences as mifepristone users. They tend to view the method as responsible for generating more egalitarian clinical interactions (and to endorse it as such), but the variation present in their evaluations demonstrates most clearly the power of caregivers' interpretative work in shaping clinical interactions. In assessing their experiences with mifepristone, caregivers demonstrate their interpretative work 'on' clients, which is enmeshed with their sense of who they are as medical workers.

KEYWORDS *abortion; RU-486; medical abortion; medical work; mifepristone; women's health care*

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In this article we examine retrospective accounts of health care workers who participated in the Population Council's clinical trials of mifepristone (RU-486) between October 1994 and September 1995. We conducted focus groups at all 17 trial sites after the trials were completed but before any data from them were processed (from October 1995 to March 1996). Seventy-eight health care workers participated in our focus groups. Here we focus on providers' reflections upon the altered power dynamics between them and their clients during the clinical trials, and on their perceptions of the implications of these changes on the future provision of non-surgical abortion. Our data are not meant to represent clients' views of mifepristone abortion; but rather, to elucidate caregivers' perceptions of medical interactions.

Drugs such as mifepristone and methotrexate, a cancer drug now used off-label to initiate early abortion (see Hausknecht, 1995), make possible a new kind of abortion, termed 'medical abortion,' which is completely different from the surgical abortions health care workers in the USA are accustomed to providing. With medical abortion, workers do not perform the abortion; they offer preparatory counseling, prescribe the pills, carry out preliminary and follow-up exams. Women using mifepristone or methotrexate may (depending upon protocols) abort outside of abortion clinics or doctors' offices. Thus, health care providers who offer medical abortion will, they believe, lose some measure of control over abortion services. At the very least, providers report, the client-caregiver relationship shifts from a central focus on the *event* of surgery, where the doctor is the actor and the client is acted upon, to the *process* of abortion, in which the client may be seen as acting upon her own body. Indeed, if all goes smoothly during a medical abortion, a client need never encounter a physician.

We decode participants' narratives on power by differentiating between the notion of *power over* others (or domination) and *power to* accomplish or enable positive development (or 'empowerment,' or transformative power) as articulated by Nancy Hartsock (1981 [1974]) and Adrienne Rich (1986 [1979]). Health care workers tended to believe their clients gained control or power in their abortions, insofar as they felt free of unwanted medical constraints or intervention. They saw them as 'empowered' (both as independent actors and as clients assisted by staff members) to the extent that they perceived that clients experienced this power as positive. Power,

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in this situation, is not synonymous with volition; no one undergoing any medical treatment has complete control over the process. In other words, women using mifepristone and misoprostol cannot control *how* the drugs work, though they may feel more 'in control' of the experience than they would during a surgical abortion. Focus group participants always invoked surgical abortion as a reference point to assess medical abortion (see Simonds et al., 1998). Health care workers may feel they lose *power over* their clients (as clients gain a sense of control over abortion), and they may regret this loss. Or, in contrast, caregivers may not perceive power dynamics as a zero-sum game. They may never have relished having power over clients; they may welcome mifepristone abortion as enabling a leveling of power. They may themselves feel 'empowered' as they offer clients a different abortion experience.

Of course, these micro-level issues take place within a larger sphere. Medicine is an institutionalized system of knowledge and surveillance that keeps 'bodies' in line (Foucault, 1973, 1980 [1978]; see also Ehrenreich, 1978; Zola, 1978; Brandt, 1985; Friedson, 1986; Rosenberg, 1987; Conrad and Schneider, 1992 [1980]). Medicine both reifies and shapes power dynamics in society at large, and it is itself constantly in flux, as people and movements shape it.

Women's medical experiences have been especially well documented by sociologists – as disempowering (see, for example, Shaw, 1974; Rothman, 1982, 1986; Oakley, 1984; Martin, 1987; Lorber, 1997). For nearly 30 years, feminist health care activists have worked to challenge the medical model's authoritarianism, and to politicize health care and procreative freedom as political issues (see Ruzek, 1978 and Staggenborg, 1991 in addition to those cited above). Many clinics established in the 1970s (and thereafter) to provide gynecological and abortion services explicitly sought to counteract typical aspects of conventional medical interactions such as the objectification of women's bodies and the pronounced power imbalances between doctor and patient (Ruzek, 1978; Joffe, 1986; Simonds, 1996). In keeping with this legacy, most of the participants in our study believed that their workplace should or did offer 'feminist' or 'woman-centered' care. However, they did not necessarily strive to achieve completely non-authoritarian arrangements between health care workers (especially physicians) and clients (as advocated by Webb, 1986). A feminist abortion clinic worker may wish to demystify medical authority, but as long as a doctor is necessary to perform abortions surgically, she cannot alter clients' ultimate dependence on medical authority. (Doctors who participated in our study rarely explicitly discussed a commitment to the goal of medical demystification.) In addition, because of the gradual transformation of clinics from social movement organizations into service providing agencies that had to function as businesses within a social climate where alternative organizational forms and methods were (and are) considered suspect, many abortion clinics do not challenge conventional caregiver-client relations. (See

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Staggenborg, 1991; and Simonds, 1996 for a discussion of one clinic's transformation.) Nonetheless, we believe that abortion workers are more likely than workers in other medical subspecialties to be aware of power issues in medical work simply because abortion is such a politicized issue, and because the vast majority of abortions are performed in a clinic setting, rather than in 'conventional' private gynecologists' offices (and thus more likely to be mediated by social service workers).

Because it is such a highly politicized issue in the USA, abortion provision is a stigmatized and dangerous activity. Abortion workers literally put their bodies on the line by going to work. As the feminist health care movement expanded in the 1970s, so did the antiabortion movement, which had begun organizing even before the Supreme Court's *Roe v. Wade* decision in 1973. The leaders of this countermovement have always endorsed aggressive methods; the violent tactics of antiabortionists escalated over the course of the 1980s, and turned murderous in the 1990s (see Terry, 1989; Faux, 1990; Blanchard and Prewitt, 1993). Between 1977 and 1991, there were 1187 'incidents of violence and disruption' against abortion providers (Blanchard, 1994). Since 1993, nine abortion workers (of whom six were doctors) have been murdered, and several others have been seriously wounded. This is not a conventional medical context, yet abortion work is routinized even in the face of such peril (see Simonds, 1996).

Abortion is, thus, something of a 'special case' in terms of caregiver-client relations. And clinical trials, from which our data emerge, make this report even more particularized. (Indeed, the attempts to undertake US clinical trials, and to locate companies willing to manufacture and distribute mifepristone were delayed by political opposition at every step. The FDA labeling of mifepristone [under the trade name Mifeprex] was completed in 2000, and the drug is now available in the USA.) Nonetheless, we hold that caregivers' reconceptualizations of power relations with their clients in such a situation bear relevance to medical interactions in general because the power issues are highlighted from the outset by the political turbulence surrounding abortion. Thus, these data may shed light on 'normal' medical interactions because they take place under 'abnormal' circumstances, just as the disruptions of 'normal' organizational practices in abortion provision brought about by the clinical trials served to make power issues especially evident to caregivers.

Medicine may be analyzed as a professional milieu in which workers are hierarchically arranged in terms of power and prestige (see, for example, Melosh, 1982; Lorber, 1984; Fisher, 1986, 1993; Friedson, 1986; Chambliss, 1996). Through this lens, medical workers' discussions of power also tap into issues of identity; in other words, these retrospective accounts may be read as telling as much about who these workers want to present themselves to be as they are about the experiences they or their clients had with mifepristone (see Goffman, 1959, 1961 and Garfinkel, 1967 for discussion of symbolic interactionist and ethnomethodological identity issues

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pertinent to medical interactions). Providers may have a vested unconscious interest in positively evaluating anything they do. Along these lines, talk about provision of services may be seen as a representation of ideas (and ideals) of professional selfhood. Since medical workers typically play a dominant role in shaping clinical discourse (see, for example, Mishler, 1984; Silverman, 1987; Fisher, 1993), the fact that they perceived the power imbalance as shifting in clients' favor may well impact their views of themselves as abortion 'providers.'

Methods

After the trials were completed (in September 1995), we worked in pairs conducting focus group interviews with providers at all 17 trial sites, from October 1995 to March 1996. We sought to elicit health care workers' retrospective assessments of mifepristone as an abortion method. Our interviews took place before any data from the trials were released by the Population Council and before the FDA met to consider approval of mifepristone. Most participants were aware, at least generally, of the statistical outcomes of the method at their own sites.

The Population Council selected trial sites to include a variety of practice settings: Planned Parenthood affiliates ($N = 8$), university research settings ($N = 5$), privately owned clinics ($N = 4$), including a Feminist Women's Health Center. We have labeled the sites by region, and assigned each site within a region a number. Sites include: East One through Six; Midwest One through Five; West One through Four; and South One and Two.

We used a uniform moderator's guide that we pre-tested and revised slightly after conducting two pilot focus groups at one site (South One). (At every other site, we conducted one group.) Primary investigators (PIs) or designated contact people at each site assisted us in organizing the focus groups by recruiting staff members and arranging a meeting site. We asked contact people to invite staff members who were 'most involved' in the trials, and told them that focus groups worked best with six participants or fewer. Groups ranged in size from two to eight participants, and the interviews lasted an average of an hour and a half. All interviews were transcribed verbatim. In all, 78 health care workers participated in our focus groups (roughly three-quarters of all staff members who were involved in any aspect of the clinical trials). PIs may have had a vested interest in presenting their 'best' or most enthusiastic staff members to representatives of a funding agency. Additionally, focus group interviews may yield discourse that demonstrates the group's common culture or shared understandings; thus, it is possible that people would feel able to be more frank in a one-on-one interviewing situation. We did observe lively conversations, including many instances where people disagreed with each other and where people aired negative views about the clinical trials – though, overall, the response was positive.

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Among the participants, 11 were physicians; 28 were mid-level providers – nurses, nurse-practitioners, nurse-midwives, and physician assistants (or some combination thereof); 26 were health workers with no medical degrees – counselors, patient advocates, research assistants, and clinic assistants – and 13 were administrators without medical degrees. (Some of those with medical degrees as well as some of the health workers did administrative tasks as part of their jobs during the clinical trials; likewise, some of those who called themselves administrators interacted more as ‘counselors’ with clients during the trials.) Six of the physicians were men; the rest of the participants (72) were women. (The vast majority of workers in abortion clinics in the US are women.) We have given all participants pseudonyms.

At the start of each focus group interview, moderators asked participants to fill out a brief questionnaire, responding to these questions: ‘Which method of early abortion do you think women prefer? Why?’ ‘Which method do you prefer, as a provider? Why?’ ‘Do you think you would ever choose to have a mifepristone abortion? Under what conditions? What do you find appealing/unappealing about it?’ Seventy-six of the 78 participants completed questionnaires (one woman physician, and one administrator did not). After completing the questionnaires, participants were asked as a group: to discuss how their site came to take part in the study; to describe the range of their own – and their perceptions of their clients’ – experiences with and views about mifepristone abortion; and to speculate upon how the method should be best offered and used. Lastly, we invited participants to share and discuss their responses to the initial questionnaire. Each participant was paid \$15 at the end of the interview, except for participants in the pilot groups at South One, who were paid \$10 each.

Mifepristone abortion

A bit of background information on mifepristone, as well as the clinical trial protocols and results, facilitates an understanding of caregivers’ retrospective accounts. Methods of non-surgical early abortion have been used in 20 countries around the world since 1981. Clinical studies of mifepristone have been conducted in France, Great Britain, China, Sweden, and the USA. The US trials were conducted between October 1994 and September 1995, after long delays caused by antiabortionist opposition to use of the drug in the USA. In the US trials, 2021 pregnant women within no more than 63 days of their last menstrual period (LMP) took part. All client-participants agreed, as part of informed consent, that they would have a surgical abortion if the mifepristone/misoprostol regimen were ineffective. These women first took 600mg mifepristone orally. Each client returned two days later for 400µg oral misoprostol. (Mifepristone inhibits the production of progesterone, without which a pregnancy cannot continue. Misoprostol, a prostaglandin, causes the uterus to contract and

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initiates an abortion if mifepristone has not begun to do so – usually within 24 hours. Without misoprostol, mifepristone may take weeks to work on its own, and has a lower rate of success.) After taking the misoprostol, women remained in the clinical setting for at least four hours, where they were closely monitored by staff members; a majority (60 percent) aborted within five hours of taking misoprostol (Spitz et al., 1998: 1243). Two weeks after this visit, each client returned for an exit interview and physical examination. (Women could opt for a surgical abortion at any time and for any reason during their participation; 2.6 percent did.) In total, 2015 women completed the trial. For women whose LMP was 49 days or less, the success rate of mifepristone/misoprostol was 92 percent; for those whose LMP was between 50 and 56 days, it was 83 percent; and for those whose LMP was between 57 and 63 days, it was 77 percent (Spitz et al., 1998: 1243). These statistics are comparable to results from previous studies conducted in other countries.

Presumptions of power

Abortion workers often interpret unplanned and unwanted pregnancy as a loss of control over how a woman wants her life to proceed (see, for example, Joffe, 1986; Simonds, 1991, 1996). Along these lines, many focus group participants tended to view mifepristone abortion as a superior vehicle for restoring control than surgical abortion. These caregivers said that they believed women chose mifepristone specifically because it gave them more control or power than they would have had if they had chosen surgical abortion.

Christine: The words they used most often were, 'I'm in control,' or 'I'm in charge of what happens to my body.' [Social worker, South Two]

Barbara: I think for those people who wanted to be in control of the situation, it [mifepristone abortion] was a really positive thing because they felt like *they* were doing this. We weren't doing this for them. [Clinic assistant, East One]

Caregivers' comments may reflect both what clients told them and their own interpretations of what they observed as they watched women use mifepristone/misoprostol. These positive comments also may be seen as justifications of caregivers' work: indications that they are accomplishing the goal of improving their clients' experiences by offering mifepristone abortion. We asked focus group participants to personalize the issue by writing about and discussing whether or not they would ever have a mifepristone abortion. One health worker's oral elaboration on her written response to this question indicates that the power involved in mifepristone abortion may be conceived as resonating broadly, transcending the politics of medicine:

Gail: I would choose the medical abortion, because even if nothing horrible would happen to me [during a surgical abortion], personally, I just think as a

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woman, and especially as a woman in relation to the medical establishment in this country, a lot of times you end up in the position where you feel like things are being done to you . . . And even if I knew the doctor, even at [this clinic] where they're really nice and they hold your hand and they talk to you - still you're basically lying down and somebody's doing something to you. I would feel better if somebody gave me a drug and said, "This is what the drug does. This is what happens when you take the drug." I would feel more like it was something - maybe not that I had control over, because once you take the drug you really don't have control over that. But . . . I wouldn't feel like I was on the receiving end of something being done to me. I think a lot of women are in that position, not necessarily with the medical establishment, but in general. [Health worker, South One]

Gail implies a link between the doctor's insertion of instruments and other experiences in which women are denied agency. Thus, to her, choosing mifepristone may be seen as a reappropriation of power denied to women, a transformation of domination into empowerment.

Caregivers said they would choose the method over surgical abortion for the same reasons they believed their clients did: because it could be done early; because it meant avoiding surgical intervention, and because it would enable women to have more 'control' over the abortion process. A majority (51 people, or 67 percent) of those who completed questionnaires wrote that there were circumstances under which they would (or might) elect to have a mifepristone abortion over a surgical one. They viewed home use of mifepristone abortion as especially attractive, because it would make abortion truly private. Even among the 10 physicians who completed our questionnaire, only three (all of them men) said they would not (hypothetically, obviously) use the method.

Powerful positions

Julie, a nurse-practitioner, described how mifepristone changes the whole setting and set-up of abortion. No longer is the woman in the vulnerable position of a gynecological patient *during her abortion* - flat on her back, legs spread, and feet in the stirrups:

Julie: I think the experience of walking in - vertical position - sitting down dressed in your normal clothes, never changing out of them, being given an innocuous thing like a pill that you swallow, remaining clothed except for the . . . bathroom part. We were in the bathroom a lot with them and . . . it's interesting how people can forget once you're a professional with a white coat and they're a patient - how easy it is to let that boundary down - and we're sitting there with bedpans and blood and, you know, people are half butt-naked. *That* seems to be okay . . . It isn't the same as the process of going, getting undressed, putting on . . . the patient gown, lining up one-by-one, going in, lying on that table. I think that's the control I'm talking about. [Nurse-practitioner, East Six]

Like Julie, many focus group participants saw mifepristone abortion as

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appealing to women because it differed from conventional gynecological treatment in terms of the positioning, objectification, and penetration of women's bodies. Indeed, clients around the country praised mifepristone abortion for its non-invasiveness, in follow-up visit questionnaires designed by the Population Council, which were part of the trial protocol. We do not have more specific data on how clients defined 'non-invasiveness,' but these facts remain: every client who took part in the clinical trials was examined internally at least twice during the study, and typically, each had two (but sometimes more) sonograms done with a vaginal probe. The average length of time clients spent in the conventional gynecological position was at least double the time it would have taken to perform a surgical abortion. That clients called mifepristone/misoprostol abortion non-invasive suggests that surgical abortion is *the* invasion worth avoiding.

Perhaps the gender of the staff members with whom they interacted was relevant to clients' perceptions of mifepristone as a non-invasive method, or the invasiveness of the preliminary and post-abortion examinations was diminished or offset by the positive attention trial participants received from staff members. All clients spent considerable time with women counselors or lay health workers, and most encountered women mid-level providers rather than male doctors performing their pelvic examinations. In contrast, the physicians performing surgical abortions at the sites in our study were more likely to be men than women. The fact that clients spent so much time together may have increased clients' comfort level, and made them less likely to see exams as invasive. Of the clients in the US clinical trials, 51 percent had had one or more surgical abortions prior to using mifepristone (Spitz et al., 1998: 1242); presumably a majority were performed by men physicians.

Control is something one can experience in some ways but not in others, simultaneously. As Julie describes, clients may seem to feel an overall sense of control based on maintaining a sense of dignity and bodily integrity during mifepristone abortions, yet they must rely on the assistance of others (to various degrees, depending on their experiences with the drugs). As she depicts it, the nursing clients received during the clinical trials might enhance their dignity (care, reassurance, help cleaning up blood or vomit).

With mifepristone, clients are asked to monitor and report on their bodily emissions; thus, they must be more involved than they would be in a surgical abortion, even if they do not literally control the process. Several providers emphasized that women who chose mifepristone had to be able to 'commit themselves' to the abortion process, stating that the method attracted - or worked best for - women who were more willing (than women having surgical abortion) to be aware of what was going on during their abortions:

Celeste: There definitely were some women who were real clear that they wanted to be *with* their abortion. That they wanted to have the control over it, and the

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time and the space to be with their own bodies while this was happening. [Nurse-midwife, West One]

Stacy: I think that, like, they feel like they have more control with the mifepristone so they're more *willing* their bodies to expel the fetus. You could see a lot of time they were almost concentrating. [Assistant clinic manager, West Two]

Heather: They have to be willing to actively participate. It's not done *to* them. They go through it. [Nurse-midwife, South One]

As focus group participants portrayed it, control means taking responsibility: mifepristone/misoprostol users become, in a sense, their own abortionists. Clinic workers become facilitators of these experiences, but their role is diminished (compared to their role in surgical abortion). It may be that this loss of responsibility means that abortion workers are somehow relieved of the stigma of abortion provision, and they experience this change as a relief. No one in our focus groups spoke of feeling that the political burden of abortion provision had lessened for them, specifically, during the clinical trials; but they clearly agreed that mifepristone might thwart the efforts of antiabortionists to target providers in the future.

A few participants said that the act of swallowing the mifepristone tablets became an emotionally charged event:

Nora: The number of people who sat and looked at those pills – and you could see them deciding whether they were going to take that step or not – was amazing. It was not just, 'Okay, here. Take this pill.' It was: people made that decision, and they did this themselves. And that's a big difference between medical abortion and surgical abortion. [Physician assistant and study coordinator, Midwest Five]

With surgical abortion, there may well be moments that crystallize women's decisions to abort – moments which medical staff may be less likely to witness or hear about. Pills-about-to-be-swallowed may have the same symbolic resonance as lying down on an exam table, or spreading one's legs for a doctor to begin a surgical abortion. In both cases, a woman makes the decision, but with medical abortion, her act directly initiates the abortion.

After Nora's comment, a conversation ensued in which focus group participants debated whether such an act could be perceived as 'empowering':

Rod: For some people that's empowering but I think for more people than we think it's not empowering. It definitely makes it harder. [Physician]

Vera: Yeah. *They've* done it. [Clinical research assistant]

Nora: And it's not the majority of people . . . I always ask when we get to that point, 'Are you a hundred percent sure this is what you want to do? Because this is the last good place to back out.' And 75 percent of people say, 'Yes. Absolutely. Hand it here.' But for that 25 percent, it's a tough thing . . . [Physician assistant]

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Rod: There's a small percentage who say it's empowering. It's a small percentage who say, 'This is a big deal. I've got to swallow these pills.' [But] I think the percentage of people who say it's a big deal is much greater than the percentage of people who say it's empowering.

Irene: Do you remember anyone from this summer that said that it's *empowering*? I never got that feeling. [Clinical research assistant and second year medical student]

Nora: It wasn't something that you would necessarily have picked up on because they would simply have fit into the group who said, 'Yes. Hand it here. I'm ready.' [Midwest Five]

Each of these focus group participants believed women using mifepristone felt a sense of responsibility for their abortions that was highlighted by the method itself; they disagreed about whether users experienced this heightened responsibility as actual empowerment.

The 'mifepristone type'

In contrast to the previous discussion of control at Midwest Five, where participants debated whether clients' desire for empowerment was a motivating factor in their choice of mifepristone abortion, consider this exchange from our focus group at West Four:

Josh: Well, I think one major difference that's relevant to the technique is the physical process of passing the pregnancy. And for some women they viewed that as very positive - that they could actually feel that they had gotten rid of the pregnancy - as opposed to a surgical procedure where it's sort of taken out of them. Instead, their own body is pushing it out . . . Before they went home, a lot of them expressed . . . *satisfaction* that they knew that their body had done what it had been asked to do by the medicines, if you will . . . [Physician]

Val: I don't think . . . there were as high a percentage of women who went home at the end of their procedure with the certainty that you do after a surgical procedure . . . These are the women who are really willing to experience the unknown. And I think a different kind of woman wants a surgical abortion because she wants it done, taken care of . . . [Physician]

Lynn: See, I really felt that when I talked to them on the phone and when I was signing them up. Certain women - I could see more and more which ones that it wasn't going to work very well [for] because they wanted everything laid out - everything. 'I want to go in at this time. I want this done. And if I leave now, tell me when it's going to happen.' Those women were not the mifepristone type. [Registered nurse]

Josh: You really have to be a go-with-the-flow type of person to have a medical abortion. Whereas the obsessive-compulsive types really need a surgical procedure.

Val: Well, you know, it was interesting to talk with the women who worked in the clinic because they all just kind of went, 'There is no way I would do this.'

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And you know what? There's no way I'd have a surgical abortion. I'd be one of those people who'd just go on and bleed and bleed and bleed.

According to these health workers, clients who took part in the clinical trials wanted to feel involved in their abortions; had the ability to wait patiently for their abortions to happen; and were willing to *give up* the sense of 'control' that comes with knowing exactly what would happen when. Clients exhibited a kind of self-reliance that, as the focus group participants assessed it, allows them to accept the unpredictability of the method. In this focus group interview, health care workers contrasted 'go-with-the-flow' types, who were confident about their bodies, with 'obsessive-compulsive' types, who seemed to demand control, but who really wanted constant reassurance and quick results. These providers endorsed women who choose mifepristone abortion as healthy agents of their own care.

Not all workers who discussed mifepristone users' (perceived) desire for power or control spoke approvingly. Health care workers might resent a client's desire for agency as an irritating demand for special treatment; an encroachment on medical turf; or a challenge that connotes mistrust. Consider this assessment of the 'mifepristone type':

Lucy: I had a distinct feeling that these women were, on some level, difficult patients ... There was always a personality trait that these were women who had control and very clear ideas that that's the way they wanted stuff to go ... They were a very demanding set of patients. [Clinic director, East One]

The 'mifepristone type' of client may be seen as excessively controlling or as gracefully letting go, empowered in her trust in her body. The 'same' phenomena are perceived in very disparate ways, ranging from approval of clients' motivations and behavior, to disapproval and suspicion. The range of providers' interpretations of the motivations of clients indicate that the method, itself, is not the root cause of clients' behavior. Participants share the view that women who choose mifepristone play a more active role in health care interactions, regardless of whether providers like it or not.

Class clashes

Focus group participants at several sites linked clients' desire for control over abortion to class status, saying that middle-class or wealthy women were more likely than poor women to choose mifepristone abortion because they had better access to information about health care options, had more disposable time, or were more accustomed to experiencing control over life events as a result of their class privilege. The ability to articulate a desire for control in health care matters may, in and of itself, be an indicator of elite status, a sort of luxury.

Jim: I think these tend to be the women who ... have these issues or at least are able to express the issues of control. [Physician]

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Aileen: But do you think that was a bias on who we picked? Because some were intelligent and had better health status? [Counselor]

Cynthia: They seemed to be more informed? [Research nurse]

Aileen: That I was more choosing those people rather than --

Jim: But I think that's always true. I think poor women don't have the choice frequently so they're unable to express their needs for control in their lives ...

Christine: I think another component of that is time. Many women who would opt for this are women who have -- if you have disposable income, you have disposable time. And women who have less money, resources, whatever, are going to have less time ... They're more likely to take it [surgical abortion] because they just don't have the other support systems to negotiate [mifepristone abortion]. [Social worker, South Two]

Aileen and Cynthia initially avoid invoking class disparities, but this seems to be what they mean when they describe clients as 'intelligent,' 'more informed,' and with 'better health status.' Jim frames the class issue in terms of privilege (and lack thereof); Christine concurs, describing the choice of mifepristone abortion (given the demands of the clinical trials) as requiring access to resources that would be greatly constrained for poor women. Their discussion also highlights the subjective use of 'objective criteria' by staff members determining whether or not women could participate in the clinical trials. The protocol included the question: 'Is the patient unlikely to understand or comply with the protocol requirements?' in its section on exclusion criteria. Many staff members, like Aileen above, indicated that they sought to determine whether a woman would be a good candidate based on her general demeanor during introductory conversations (on the phone or in person) and her attitude about making three clinic visits.

At West Three, a research site that did not routinely offer abortion services before or after participating in the mifepristone trials, workers contrasted their mifepristone clients with the clients they usually encountered in contraceptive method trials, identifying class and ethnic divisions:

Debbie: Most of the women we had make more money than we do [Registered nurse].

Elena: The presents they brought us cost more than the abortion. [Laughter.] [Health worker]

Amy: That's another interesting point about this study was the main share of our patient population is Hispanic in this clinic. [Health worker]

Debbie: Lower income.

Amy: Lower income Hispanic. The main share of the population for our abortion study was middle- and upper-middle class.

Elena: Anglo women ...

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Wendy Simonds: Why do you think that was? [Moderator]

Debbie: They were the ones who were educated to have heard about it and read about it.

Wendy: People didn't get referred to you from other clinics?

Elena: Well, from a lot of *private* clinics. And also, traditionally, Latin women tend not to abort as often as -

Debbie: Well, they're not as keyed in to the body. This is a very early method.

All of the women who worked at this site, except for Amy, were Latinas. When Elena posited that white women would be more likely to abort than Latinas, Debbie deflected her remark by linking class and ethnic privilege with education and being 'keyed in' to the bodily changes of pregnancy. These focus group participants described how rich clients would sometimes be hostile toward staff members when they arrived: annoyed that they had to negotiate parking in a part of town they considered dangerous and come to a county hospital known for serving poor people. The clients would, of necessity, come to trust the staff, and would be very needy of attention during their second visit (when most aborted), workers said. Elena, who was most disparaging of this new 'population,' portrayed clients as callous about abortion:

Elena: Whether they're anxious, worried, cramping, crying, whatever [during the abortion] - after it [the embryo] passed, we had one sitting in here, she's going to go to the Galleria Christmas shopping! And she looked better than the staff. As soon as they come out, they comb their hair, put a little lipstick on. Is this the same patient that was here earlier looking like death on a windshield?

Elena sounds as though she would have preferred clients who expressed sadness after the procedure was over. Instead, she saw the vulnerability of these women vanish as they reassumed their original demeanor, exuding superficiality, which she associates with ethnic and class privilege.

Caregivers' perceptions of clients' demands and behavior, focus group discussions demonstrate, are linked with their ideas about privilege and oppression, as well as with their personal views about the gravity of abortion. Their narratives indicate that they evaluate clients' demeanor and behavior comparatively, formulating opinions about clients' moral worthiness.

Compliance and independence

Health care workers' views about power relations with clients surfaced most obviously in discussions of whether women should be able to use mifepristone/misoprostol at home or be required to remain in medical facilities for four hours after taking it (as was the case during the clinical trials). We encountered a range of views about home use. Some providers responded

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conservatively, voicing mistrustfulness, protective paternalism, or medical dogmatism. Others were more liberal or radical, offering feminist critiques of conventional care: recommending that clients' needs be made central and that staff members should work to enable clients to actively participate in their own health care. Participants agreed that the clinical trials disrupted their normal routines. While no one explicitly said s/he approved of home use because it would be less disruptive, routinizing four-hour clinic or office stays would be logistically and spatially difficult.

Some providers clearly wanted to maintain control over their clients because they did not trust them on their own. Others framed the issue as one of nurturance rather than medical expertise, saying they wanted to be able to offer what they considered to be vital care to women. These providers believed that women also *wanted* to be monitored and cared for in this manner. A majority, even those taking a somewhat paternalistic attitude, felt comfortable letting clients decide whether they could deal with aborting on their own. At the conclusion of each client's participation in the clinical trials, staff members were asked to evaluate whether they believed she would have been able to use the method at home. At all but two sites, providers felt that 90 percent or more of their clients could have safely used the method at home.

At the conservative end of the spectrum, a few providers wanted to control clients' behavior absolutely. In this excerpt from the discussion at Midwest One, providers begin by taking a paternalistic stance and expressing a strong sense of mistrust toward clients:

Kendall: They should be in the clinic so they can be cared for. [Nurse's assistant]

Martha: I have a difficult time with non-compliance. That bothered me a lot. I was very surprised that women who signed an agreement to come for all the visits did not do it. It bothered me a lot and I really feel that maybe they need more supervision . . . [Registered nurse]

Alice: They should take it here because basically [of] the non-compliance. They should be taken care of because of non-compliance. [Patient advocate]

Martha: We still have a couple of patients, we don't know if they've aborted or not . . . I've sent registered letters. I've called. One in particular did not abort here and none of her addresses or phone numbers were valid . . . Plus, I think a lot of these women *want* to be here. My impression is that most of the women wanted to be supervised. They felt more comfortable having a medical person around.

For these workers, the question about home use led immediately into a discussion of non-compliance. These participants could not understand why clients in the clinical trials would not follow through with the trial protocols. Though staff members were accustomed to the fact that after surgical abortion a significant proportion of clients typically do not return for follow-up, they viewed participation in the clinical trial as something that

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obviously merited strict monitoring and documentation. They expected that clients would take follow-up as seriously as they did, and that they would understand trial participation the way that they did. The resentment of these focus group participants at the failure of a few women to return for follow-up visits served as evidence for them that clients' compliance must be enforced as strictly as possible (by keeping women in the clinic to abort), and made them unwilling to trust any women on their own.

We believe that underlying the claim that clients need supervision (bolstered by the claim that they *desire* supervision), lurks the fear that medical professionals will be held liable for women's non-compliance. It was not uncommon for workers to discuss the damage that could be done to abortion providers, as well as to the general reputation of mifepristone abortion, if lawsuits were to arise. Workers feared that a lack of supervision might translate into malpractice claims. Many felt that compulsory monitoring of women using mifepristone, at least at the outset, would help forestall such problems. However, data show that home use works quite well; in one study the success rate was 98 percent (Schaff et al., 1997; see also Ellertson et al., 1997).

Some workers clearly saw non-compliance as negligent behavior on the part of clients, even though, in reality, failure to return for follow-up may have nothing to do with compromising one's health status. Abortion workers are accustomed to observing what they consider to be a lack of proper self-care or irresponsible, even dangerous, behavior among their clients; and this makes some of them wary of granting women more control over abortion. As Mary, a health worker at South One said:

Mary: We're used to women ... [who] don't follow-up, they don't take antibiotics, they don't come back for aftercare. We ... [had] a woman who - she'd retained tissue. She went to the emergency room and had retained tissue and would not come back into the clinic to be re-aspirated. She had a raging infection ... When you're fooling with your health - but for some reason they just ... [she trails off]. [Health worker, South One]

Part of what underlies workers' dismay is (typically) their own heightened conscientiousness about procreative health, safe sex, and pregnancy prevention. As for abortion, they know everything there is to know about the bodily responses that indicate that something could be wrong afterward, and would not make the kind of mistake Mary describes above, of letting a problem go on until it required emergency treatment and could jeopardize future procreative health.

Many focus group participants recalled that, during the clinical trials, they worried about letting clients go home without having aborted for reasons other than anxiety about compliance. Their worry may indicate their wariness about the efficacy of this method because it was new to them, or it may be evidence of their desire for control over medical procedures, or both. Workers are accustomed to the predictability and finality of surgical abortion, and medical abortion is very different:

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Donna: When our [surgical abortion] patients leave at the end of the day, we know that they're okay. We know that we can go home and sleep. We know that it's complete -- or if it's not complete . . . what follow up we need to do with that patient. Where, with the mifepristone, you didn't. [Counselor, Midwest Three]

Josh: I had a tremendous amount of discomfort around sending these women out who had taken these two drugs and there was still a pregnancy in there . . . I was pretty confident that they probably would [abort] but I had no idea when and what experience they'd go through. To me that is a very uncomfortable part of this. That's my own anxiety. In fact, I think the women really did quite well with it. [Physician, West Four]

Robin: I felt it was hard to send people off and not know what happened to them . . . When I heard that people who had hard times or ended up having to have surgical procedures, I felt awful. I almost felt like we failed them. [Nurse practitioner, East Two]

These providers worried about clients aborting at home because they felt a physical examination was necessary to ensure that an abortion was complete (and clients cannot examine themselves). 'Method failure' is not a concept caregivers associate with surgical abortion, and this makes it difficult to integrate into their ideas about treatment. They feel responsible for what a woman may experience after she leaves because it is part of the abortion for which they hold themselves accountable. Giving up this sort of control, which offering medical abortion necessitates, leaves providers struggling with the uncertainty that characterizes the method. This feeling may have been exacerbated by the fact that caregivers were, in a sense, pioneers taking part in a clinical trial.

Providers described a peace of mind as accompanying surgical abortion that they perhaps had not recognized before they missed it in their experiences with mifepristone/misoprostol. Many will undoubtedly get used to this difference in the procedure, or perhaps 'worrying' will become a routine component of providers' experiences of medical abortion.

It is possible that the routine availability of non-surgical abortion will propel abortion providers toward new methods of interaction with clients, since, at least sometimes (since the FDA labeling of mifepristone states that women should return to health care providers to take misoprostol, but does not state that they should remain there for four hours), medical staff will have to rely on clients' reporting and judgment. Abortion providers typically have short-term clinical interactions with their clients, which are not conducive to fostering mutual trust. Under these circumstances, providers -- especially physicians -- may simply find it difficult to cede control to clients. This difficulty need not be seen as solely reflecting authoritarian medical professionalism or mistrust of women's abilities to interpret potentially dangerous outcomes of mifepristone/misoprostol; as the comments above indicate, workers are concerned about the outcome of procedures they initiate, and feel a strong sense of responsibility toward their clients.

Health care workers commonly asserted that women who enrolled in the

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trial *wanted* medical monitoring; thus, some concluded that women in general would probably not desire home use of mifepristone:

Natasha: I think the women liked being at the clinic. It provided this level of security. And I know that as a feminist, I felt a lot of guilt about saying that because, ideally, I was hoping that it would be something that women could just go ahead and have more control over and take at home. [Study coordinator, South One]

Similarly, by the end of the interview, Josh, a physician, stated that, while he believed that mifepristone abortion was 'safe enough' for home use, women ought to be offered care in a clinical setting:

Josh: My concern is around the emotional side [of the abortion experience] and we should be taking care of these women as a health care system . . . Think about all the other situations in life where people go through difficult situations; there are experts there to care for them. Shouldn't we offer that same thing? I think we should. (Physician, West Four)

Expertise, as Josh characterizes it, means reassurance, nurturance. Perhaps what he proposes, and what Natasha reluctantly conceded clients wanted and got at her site during the trial, is not inconsistent with the goals of feminist health care advocacy. Though Josh sounds distinctly paternalistic and idealistic about medical care, there is a difference between requiring supervision and offering women the option of medical assistance.

Many providers explicitly opposed arguments that presumed a medical or legal necessity for women to remain in medical settings after taking misoprostol, saying clients should direct the terms of their own care:

Ariel: I think that sometimes we don't give women enough credit for being able to decide what they need and what they want and how to take care of themselves. Sure, there are young women out there that need a lot of help, a lot of hand holding. But I think, for the most part, women are able to endure stuff like this on their own and make decisions about when to take what. [Health worker, West Two]

Many providers expressed their willingness to abdicate decision-making authority, confident that clients would be able to determine the best conditions for their own care. In so doing, one doctor, Val, situated medical abortion in reference to other procreative events:

Val: It's like labor, I think. Some women do fine with absolutely nothing and you can just leave them alone even if it takes twenty-four hours, and some women have had enough when they're three centimeters and they're sick of it and [say], 'do something!' And I routinely tell . . . [women having] miscarriages, you know, you come in if you bleed too much or if you have too much pain, and we'll do something. And I'm shocked at how many women stay home and bleed for days alone . . . A lot of women really don't want to have anybody messing with them . . . And they rarely bleed to a point that's dangerous . . . Some women bleed dramatically, but I've gotten really comfortable with women bleeding like crazy at home because they choose to. [Physician, West Four]

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Val describes a woman-centered conception of care: do for each woman whatever she determines she needs, whatever she feels the situation demands. Treat each woman as a responsible actor, capable of working through difficult bodily experiences. She discusses mifepristone abortion in terms of other procreative outcomes – miscarriage and birth – in order to demonstrate that women respond in a variety of ways, and that all of these should be respected. She sees medical personnel as assistants and educators, rather than experts who ought to control women's bodily experiences, regardless of whether terminations of pregnancy are spontaneous or induced.

Guilt and punishment

While providers discussed the heightened sense of responsibility that mifepristone abortion could enable, allowing a woman to experience her abortion as an affirmative act of taking control over her life, several pointed out that there is a fine line between such responsibility and guilt. Having a mifepristone abortion might allow some clients to assuage guilt over aborting since they were 'doing it themselves,' or, alternatively, the intensity and length of the experience could exacerbate guilt feelings:

Brian: There were a couple of cases of women who had a feeling that in a way they were sort of accepting their punishment for being pregnant because they would bleed more, they would have more pain. [Physician, Midwest Three]

Belle: For some women I think it helped because it was a longer process. They were able to work through the guilt that they were feeling for terminating the pregnancy. A lot of that *mea culpa* stuff was, like, 'I am guilty. I am suffering. I am having more cramps. I am having more bleeding. I'm having more time to suffer over my choice in choosing this miscarriage rather than having an abortion.' A lot of women seemed to get real involved emotionally with that. And some it helped and some it didn't. [Licensed practical nurse, West Two]

Having control does not necessarily feel good, and may, indeed, be troubling to women, as in cases where caregivers perceived clients as using their sense of control over their abortion experiences to punish themselves for aborting.

In contrast, many health workers spoke disparagingly about clients who they felt used mifepristone abortion as a way of distancing themselves from the reality that they were aborting, or clients who chose to see mifepristone abortion as *not really an abortion* (see also Simonds et al., 1998):

Elena: They thought it was a pill that was going to – miscarriage. A birth control pill that was going to bring their period down . . . [Health worker, West Three]

Debbie: They'd call it 'the pill.' The morning after pill . . . and we were all very adamant that they understood. This is an *abortion* pill; it's going to make you have an *abortion*. [Registered nurse, West Three]

One doctor, Dick at East Three, felt that mifepristone made abortion

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'too easy,' and that it enabled women to use abortion as a 'form of birth control.' Dick saw surgical abortion as very unpleasant, commenting:

Coming from a man's point of view, I can't imagine anybody who would want a bunch of needles stuck up there to numb the cervix . . . And from doing the procedure, they just look so damn painful. I just can't imagine anyone wanting to choose that when they have the option of not having to go through it.

Dick saw mifepristone abortion as a vast improvement on surgical abortion. He only weakly endorsed mifepristone, however, remarking that he saw it as a 'nice alternative' to be used by 'patients who've been involved in rape, incest, or have some sort of medical contra-indication to having the procedure done.' In his ideal scenario, women would have to earn the right to have what he considered a better abortion, either as compensation for sexual assault or by demonstrating a 'medical contra-indication' to surgical abortion, which are extremely rare in first trimester abortions done using local anesthesia, and depend on the abortionist's perceptions of what could impede a successful abortion. (The only absolute physical impediment to surgical abortion is fibroids that are large enough to block entry into the uterus. Some physicians refuse to perform abortions for very obese women because of risks linked to anesthesia use; some see high blood pressure as a danger; some refuse to perform abortions for women who seem very nervous about the procedure, for fear they will move and a uterine perforation will result.)

Dick's authoritarian stance and his ambivalence about mifepristone highlight the fact that women will continue to have to wrestle for power with certain practitioners and to negotiate shifting legislative authoritarianism on a broader scale. The availability of a new abortion option does not automatically guarantee enhanced freedom of choice for women. Dick's view serves as a reminder that doctors often do not see themselves as service providers, but rather as arbiters of which services they will provide, and to whom. Their decision making, or their manner (anywhere on the spectrum from benevolent to punitive), may well depend upon their evaluations of patients' moral worthiness.

Providers, pills, and power: looking forward

Focus group participants were more comfortable performing surgical abortion than with offering mifepristone abortion: 35 (46 percent) preferred surgical abortion, as compared to 21 (28 percent) who preferred mifepristone abortion (20 participants - 26 percent - expressed no preference). There was little difference in provider preferences between participants with and without medical degrees; however, when participants with medical degrees are divided into physicians and mid-level providers (nurses, nurse-practitioners, physician assistants, and nurse-midwives), the situation changes. Seven of the 10 (70 percent) physicians who completed

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questionnaires preferred surgical abortion, compared to 11 of 28 (39 percent) mid-level providers and 17 of 38 (45 percent) workers without medical degrees. Only one physician expressed a clear preference for mifepristone over surgical abortion, as compared to 11 of 28 mid-level providers (39 percent); and nine of 38 workers without medical degrees (24 percent). Physicians – who play the central role in surgical abortion – prefer it most clearly, while mid-level providers – whose involvement in medical abortion is greater than in surgical abortion – find both methods appealing. There were very few providers in any category who would not want to offer mifepristone; these responses indicate their *preferences*. Providers at all but one site (West Three, where workers had no previous experience with surgical abortion) wanted to be able to offer mifepristone abortion to clients. Many expressed regret that the trial ended just when they were getting the hang of the method (see Winikoff et al., 1998). Thus, the ambivalence providers expressed (as a group) about the method or its influence on their relations with clients was clearly outweighed by their desire to give women what they want.

No doubt, caregivers want to provide mifepristone because they perceive that a significant proportion of clients would prefer it to surgical abortion; 34 (45 percent) said they thought women preferred mifepristone, as compared to 15 (20 percent), who believed women prefer surgical abortion. The rest (27, or 35 percent) responded conditionally, saying women's preferences were individual ('it depends on the woman') or situational. Research conducted in Canada, France, and the United Kingdom suggests that over half of eligible women will choose medical abortion over surgical abortion (see Ellertson et al., 1999).

In assessing their experiences with mifepristone, caregivers demonstrate their interpretative work 'on' clients, which is enmeshed with their sense of who they are as medical workers. Focus group participants ranged in their descriptions of mifepristone clients: from labeling them obsessive-compulsive about control to seeing them as relaxed 'go-with-the-flow' types; from praising them as profoundly aware of bodily processes during medical abortion (responsibility which could be heightened to the point of self-castigation) to denouncing them for being in denial about their abortions; from considering them more conscientious than surgical abortion patients to calling them more frivolous. All this talk about mifepristone bespeaks caregivers' attempts to make sense of and manage the ways in which this new service impacts their relationship with clients.

The Director of East One, Lucy, contrasted staff members' roles in medical versus surgical abortion, offering a preview of the kind of conflict that clinic staff may experience around the country once mifepristone becomes available:

Lucy: [Surgical abortion is] predictable. There's a sense of wrapping up. And with these medical abortion people . . . you don't know what's going to happen. Is it going to happen or isn't it going to happen? It's a messy process that is not

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at all pleasant, I think, for the staff and for the women themselves. I think it takes a certain kind of person . . . Ann, as a midwife – I was really struck by the difference . . . Having gone through a lot of deliveries with women, she was more attuned to sort of waiting it out with the women and was less frantic about the bleeding . . . There was some conflict between Ann's reaction and the reaction on the part of some of the other nurses who were immediately wanting to intervene. And even some of our doctors, you know, 'Let's intervene right away. Stop this.' Because that's what you would do in a surgical setting, but not necessarily in a medical [abortion]. It takes a more relaxed holistic approach and that created a lot of conflict for us. [Director, East One]

Lucy's view of mifepristone abortion as 'less pleasant' than surgical abortion relates to the variability and unpredictability of clients' experiences as compared to practitioners' control of surgical abortion – that is, the way in which abortionists have come to encapsulate surgical abortion within their own parameters. These parameters do not fit non-surgical abortion, and so the more conventional the caregiver or the more uncomfortable with change, the more likely s/he would find her/himself at odds with the method. In contrast, providers who approve of renegotiations between practitioners and clients were more enthusiastic about the abortion experience mifepristone – and non-surgical abortion in general – made possible for both caregivers and clients. Caregivers' general willingness to continue offering mifepristone indicates that the sort of conflict Lucy describes may yield, in the long run, a 'more relaxed holistic approach' that significantly revamps caregiver–client power relations.

Medical abortion may alter the provision of early abortion in other ways that are politically beneficial for women. Since physicians need not provide surgical abortion routinely in order to prescribe mifepristone, its availability may increase women's access to early abortion. Eventually, women may be able to actually abort in the privacy of their own homes. In addition, more diffuse provision and private use would mean that clients would be less likely to face antiabortion opposition in their abortion experiences. Medical abortion may revive a focus on power relations in medical interactions that faded as the goals of the women's health movement gradually transformed from grassroots activism to establishing institutionalized resources and service provision. In sum, medical abortion may trigger changes that significantly reduce the vulnerability clients experience in medical interactions.

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