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TRAP laws and the invisible labor of US abortion providers

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Abstract

Targeted Regulations of Abortion Providers (TRAP laws) are proliferating in the United States and have increased barriers to abortion access. In order to comply with these laws, abortion providers make significant changes to facilities and clinical practices. In this article, we draw attention to an often unacknowledged area of public health threat: how providers adapt to increasing regulation, and the resultant strains on the abortion provider workforce. Current US legal standards for abortion regulations have led to an increase in laws that target abortion providers. We describe recent research with abortion providers in North Carolina to illustrate how providers adapt to new regulations, and how compliance with regulation leads to increased workload and increased financial and emotional burdens on providers. We use the concept of invisible labor to highlight the critical work undertaken by abortion providers not only to comply with regulations, but also to minimize the burden that new laws impose on patients. This labor provides a crucial bridge in the preservation of abortion access. The impact of TRAP laws on abortion providers should be included in the consideration of the public health impact of abortion laws.

Keywords

Abortion; reproductive health; health policy; invisible labor

Introduction

Abortion laws are proliferating in the United States, particularly Targeted Regulation of Abortion Providers (TRAP) laws, which impose restrictions on clinics and individual

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clinicians who provide abortion services (Guttmacher Institute, 2015). TRAP laws are more stringent than is necessary to ensure patient safety and more rigorous than regulations for providers of similar, but less stigmatized, procedures. Frequently, TRAP laws require medically unnecessary changes to facilities, staffing, and credentialing, which providers have difficulty meeting because of the additional time, cost, and resource burdens of these requirements (Medoff, 2012). Thus, while the stated purpose of such laws is the protection of women's health and safety, the practical consequence is often restricted access to abortion.

TRAP laws have resulted in pronounced geographic barriers to abortion access in certain regions of the country (Grossman, White, Hopkins, & Potter, 2014). In several states, clinical requirements introduced by TRAP laws have resulted in such significant institutional barriers to abortion provision that multiple clinics have closed. Provider-level restrictions have translated to increased patient costs (Baum, Grossman, & Potter, 2013; Medoff, 2008; Phillips, Grossman, Weitz, & Trussell, 2010), delays in accessing care, and decreased availability of second-trimester abortion services (Bitler & Zavodny, 2001; Jones & Weitz, 2009; Upadhyay, Weitz, Jones, Barar, & Foster, 2014). Many of these barriers are compounded for women of color and women of lower socioeconomic status (Dehlendorf, Harris, & Weitz, 2013; Finer, Frohwirth, Dauphinee, Singh, & Moore, 2006; Medoff, 2008). Such "supply-side" restrictions have not been shown to reduce the demand for abortion (Gius, 2007; Joyce, 2011; Medoff, 2010; Medoff, 2009). Instead, they make it more likely that patients will face delays, travel long distances, and, when they cannot access a provider at all, resort to extra-legal means of obtaining an abortion. While abortion is, in general, a very safe procedure (Raymond & Grimes, 2012), abortions performed at later gestational stages incur greater risks. Consequently, access barriers pose a public health threat due to the potential for delays, an increase in undesired pregnancies, and unsafe or self-induced abortions (Bartlett et al., 2004; Grimes et al., 2006; Grossman et al., 2010; Jones, 2011).

In this article, we draw attention to an additional, yet less often acknowledged, area of public health threat: strains on the abortion workforce. We introduce the concept of *invisible labor* to highlight the work undertaken by abortion providers to minimize the burden that new laws impose on patients. The concept of invisible labor, which is taken from second-wave feminist sociology of the 1970s and 80s, draws attention to the ways in which women's work is often unrecognized and largely uncompensated (Daniels, 1988; Hochschild, 2012; Oakley, 1975; Smith, 1987). More recent accounts have productively transposed this concept from its origination in the domestic sphere (Devault, 2014; Wichroski, 1994). Here, we find it useful to point out that just as the work of women can often be invisible, work undertaken *for* women can be similarly obscured.

Specifically, we argue that a framework that focuses on the impact of abortion laws on patients may inadvertently overlook the key, and often invisible, work undertaken by abortion providers to minimize the burden on women and preserve abortion access. We draw on data from our qualitative study of the experiences of abortion providers in North Carolina practicing under a new law to demonstrate that the impact of abortion laws on abortion providers forms a critical component to the public health threat of recent abortion legislation in the USA. The steps providers take to adapt their clinical practices and continue to provide

services is central to maintaining access to safe abortions in the US. Insofar as these laws may drive providers away from an already under-resourced area of public health delivery (Freedman, 2010), this represents a pressing public health problem and a missing piece of the conversation on US abortion policy.

US abortion law and the legacy of "undue burden"

Until the 1800s, abortion was largely unregulated in the US, with little thought to restrict the termination of a pregnancy before "quickening," the first perception of fetal movement, which generally occurs during the 5th month of pregnancy. In the mid-19th century, a growing community of organized physicians began to push for legal restrictions. By 1900, abortion was illegal throughout the United States (Mohr, 1978; Reagan, 1997).

States began to liberalize abortion laws in the mid-20th century following pressure from activists, who emphasized the maternal morbidity and mortality associated with illegal abortions. In 1973, the Supreme Court's landmark decision (7–2) in *Roe v. Wade* established that the right to an abortion during the first trimester was protected under a constitutional right to privacy. The Court ruled that states may have a competing interest in protecting the fetus after viability, and that the risks associated with abortion in the second and third trimester may give states the right to regulate some aspects of abortion care. However, the right to obtain an abortion was legally protected to the same standard as freedom of speech or religion, and any law that pertained to abortion access would be subject to "strict scrutiny." This standard meant that if a law restricting abortion were challenged in court, the onus was on the state to prove that the regulation did not infringe on this fundamental right (Estrich & Sullivan, 1989).

The landscape of abortion regulation changed in 1992 with the Supreme Court's decision in *Planned Parenthood v. Casey*, which challenged the 1989 Pennsylvania Abortion Control Act (PACA), which many consider to be the original TRAP law. PACA introduced what have become familiar abortion requirements: counseling with state-mandated content, a 24-hour waiting period between counseling and abortion, parental consent for minors, extensive reporting requirements for abortion providers, and spousal notification if the woman seeking abortion was married. In a 5–4 decision, the Supreme Court upheld all but one provision of the law, finding only the requirement for spousal notification unconstitutional.

With this decision, the Court upheld the legality of abortion throughout the US, but dramatically changed regulatory standards in several key ways. Under *Planned Parenthood v. Casey,* while a state could not *prohibit* a woman from obtaining an abortion prior to viability, states did have the right to *restrict* abortion, as long as those restrictions did not pose an "undue burden" on the woman seeking an abortion. An undue burden existed only if "[the law's] purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability" (*Planned Parenthood of Southeastern Pennsylvania v. Casey*, 1991). Because PACA was purportedly designed to protect women's health and safety by providing them with information, it did not constitute an undue burden (Allen, 1992; Benshoof, 1993a).

The *Casey* decision ushered in a new era of abortion regulation. While several states had passed abortion restrictions following *Roe,* most were struck down as unconstitutional under the standard of strict scrutiny. Under *Casey*, courts were now directed to consider the particular restriction and the degree to which it would interfere with the woman's ability to access abortion. States seeking to regulate or restrict abortion had a new standard to meet, and a template for a law that met this standard. Restrictions modeled on PACA spread rapidly (Benshoof, 1993b).

While TRAP laws regulate the behavior and actions of abortion providers, they ultimately add to the steps a woman must take to access abortion services. Waiting periods in three states (Missouri, Utah and South Dakota) have expanded from 24 to 72 hours, and 11 states require an ultrasound before the procedure (Guttmacher Institute, 2015). Two clinic trips are required if mandatory counseling must take place in person, or if an ultrasound must be performed 24 hours prior to the abortion. This is a departure from standard clinical practices, and results in extended timelines and additional clinical duties, which can be burdensome to both patients and providers alike.

However, the definition of "undue burden" remains imprecise and subjective. When laws are focused on patient-level variables, such as gestational age or parental involvement for minors, the imposition of a burden on the patient seems clear. Since TRAP laws target providers instead of patients, they result in burdens to patients most directly when a law will cause a clinic to close and limit women's access (Guttmacher Institute, 2015). Judicial decisions regarding the constitutionality of a particular law may thus turn on different projections of the effects of a given law, and on differing interpretations of what constitutes a significant burden. In Texas, a TRAP law (HB 2) was enjoined in district court as burdensome since clinics would close, but was then reinstated after appeal in the Fifth Circuit Court, as the Circuit Court held that the law was unlikely to represent a true burden to women (*Complaint in Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*, 2014, *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*, 2014).

Abortion provision in the United States has become a dance between lawmakers and providers. The challenge for anti-choice lawmakers is to write abortion restrictions in a way that complicates access, but not to such an extent that they impose a blatant undue burden on patients, which will not stand up in court. The challenge for abortion providers is to meet the standards of the law, which may require extensive changes to a clinic's physical structures and patient care procedures, so that they can continue to operate legally and ensure abortion access. In this way, the abortion provider, and the steps she takes to adapt to the ever-changing regulatory landscape, becomes an essential component of protecting abortion access throughout the country.

The provider impact of US abortion laws: lessons from North Carolina

Our insights into the burdens of abortion laws on providers are informed by our research on the experiences of abortion providers in North Carolina following the passage of the 2011 "Woman's Right to Know" (WRTK) Act (HB 854). HB 854 follows the template of the

Pennsylvania Abortion Control Act of 1989. The law, which is similar to laws in 37 other states (Guttmacher Institute, 2015), requires counseling with state-mandated information by a “qualified medical professional” (physician, registered nurse, nurse practitioner, or physician assistant) and a 24-hour waiting period after counseling before an abortion can be performed. The counseling must contain information about the potential harms of abortion, risks of carrying a pregnancy to term, pregnancy alternatives, obligations of the father to provide financial support, and the availability of assistance from the state if the pregnancy is continued. Initially, the law also mandated that an ultrasound be performed and the images be described to the woman; this portion of the law was enjoined and later overturned by a federal judge in January 2014. There are no provisions in the law for providers to use discretion in consideration of specific patient circumstances.

For our study, we recruited physicians, physician assistants, nurses, counselors, and clinic administrators involved in abortion provision in North Carolina (hereafter referred to as “abortion providers”). Providers were eligible if they worked under the WRTK law and had prior experience practicing in a less restrictive environment. A list of North Carolina abortion providers was compiled from the National Abortion Federation database, and the researchers’ professional networks; these providers were invited to participate. In addition, we employed a snowball sampling strategy where participants could share information about the study with colleagues, and those contacts were invited to participate as well. We conducted semi-structured, open-ended interviews with providers. With one exception, interviews were conducted in person and all were audio-recorded and transcribed verbatim.

We interviewed a total of 31 healthcare professionals who were involved in multiple aspects of abortion provision at 11 distinct clinical practices (see Table 1). Interviews covered topics including the provider’s professional history, current practice characteristics, personal experiences in providing care under the law, perceptions of how the law affected their patients and how their practice had adapted to comply. Our detailed methodology and a summary of our findings have been described elsewhere (Mercier et al. 2015).

We found that providers made major adaptations to their clinical practice to comply with HB 854. Most providers made changes not only to meet the law’s requirements, but also to minimize the burden of the law on patients. For example, they chose to implement telephone counseling rather than require two in-person clinic visits, acknowledging that attending two visits would be difficult for many patients. As one female physician working at a hospital-based academic practice described, “It would be much, much more challenging for people having to essentially make two separate visits. So that would become a much bigger barrier for people, in terms of taking time off from work, someone to bring them, transportation.”

Implementation of telephone counseling, however, required significant adaptations by providers. Several high-volume providers hired additional nurses and developed a call-center infrastructure with dedicated staff for telephone counseling. Lower-volume providers did not institute such extensive structural changes, but responded to the new requirements by changes in scheduling and work tasks. For example, nurses at practices which provided general health care alongside abortion services described leaving other clinical duties to perform the counseling whenever office staff could get patients on the phone. As one female

nurse at a free-standing group practice noted, “If an abortion patient calls and we’re in the middle of seeing other patients, we have to stop what we’re doing and try to do the counseling so that she can get in when she wants to.”

Providers who worked in small or solo-practice clinics frequently extended the hours of existing staff to meet demands. One male physician who ran an independent practice devoted mostly to abortion services reported that: “The vast majority of our calls come outside of office hours. We developed a scheduling form. We keep these at home, we keep them with us in my car...and so they call, I can get the call anytime day or night and I know we have it documented.” For him, answering phones and performing counseling in off-hours, at home, or while traveling, had become a standard way to facilitate patient access.

In making changes to preserve patient access and minimize the impact of HB 854 on patients, providers took on an increasing reciprocal burden. In general, we observed a tradeoff between cost and time burdens, depending on the practice type and structure. Some high-volume, freestanding providers reported adding the equivalent of a full-time nursing position simply to accomplish the counseling, with staff dedicated to counseling calls. Costs were greatly increased by the requirement that a licensed medical professional perform the state-mandated counseling, The clinic administrator noted at one large abortion clinic in an urban setting described the law as having “a huge financial impact ...you know, nurses are expensive.”

In contrast, for lower-volume clinics, solo practitioners, and hospital-based clinics, costs did not increase, as no additional staff was hired. However, the providers, typically physicians, described how they and their colleagues worked more uncompensated hours to meet the law’s requirements. In the academic setting, this work was generally done by resident physicians who simply came in earlier or stayed late in order to accomplish counseling calls in addition to other clinical duties. At one small solo practice, the burden was shouldered by the female physician-owner, who took on work not typically performed by a physician in order to provide care within the practice’s operating budget:

> I have to do the phone calls every Monday because [otherwise] I would have to pay overtime and they have to be registered nurses. So I’ll just do it. I answer phones, make appointments on Mondays. It used to be other staff members doing that. You see, I can’t afford to pay nurses time and a half and it used to be other lower paid staff that could come in on Mondays. Now I’ve got to do it.

All of the clinics represented in our sample continued to offer the same in-person counseling and support as they had prior to HB 854. Therefore, new staff hours did not replace any previous clinical duties. In general, providers absorbed both the financial and time burden of these changes. No providers reported increasing their prices to compensate, and several specifically stated that they made an explicit decision not to pass the cost onto patients. In discussing this decision, several providers stated that passing the financial burden onto patients would have been “not fair” or “unkind”, given that patients already struggled to pay for their procedures. Larger practices with greater resources performed dedicated fundraising activities to support the increased costs.

Many providers also described a personal emotional burden associated with the law, centered on their concern that it was ultimately harmful to women. Most providers did not think that the 24-hour waiting period benefited women, and in fact believed that many aspects of the state-mandated counseling were unnecessary, irrelevant, or potentially harmful. Echoing sentiments expressed by many study participants, a female nurse at a free-standing clinic stated that “They (lawmakers) are not looking out for the wellbeing of women, so for us who are caring about women and women’s health, it’s a great source of frustration and makes us angry and resentful.” Therefore, providers struggled to balance the requirements of HB 854 against their own commitment to provide high-quality, responsible medical care.

We found that for many providers, the emotional burden stemmed from this nexus: the law created a work burden but the burden they accepted to achieve compliance had little benefit and possible harm for patients. As one female nurse who was involved in adapting her clinic’s practices and personally performed counseling noted, “We have accommodated the pre-24 hour counseling. It’s a pain in the neck. It’s so inappropriate. It’s so undermining of what these poor families are going through.... We do it, but it’s really disturbing.”

While telephone counseling was used to minimize the burden on patients, many providers described remote counseling to be particularly problematic—especially since patients sometimes experienced the content as alienating or judgmental. Providers indicated that having initial patient contact by phone rather than in person could interfere with the establishment of trust and rapport, which they identified as essential components of compassionate abortion care. Concern for the impact on the patient and on the patient-provider relationship caused distress for several providers, as described by a female nurse who performed several consent calls each week: “It really upsets a lot of patients to have to hear all this overwhelming stuff on the telephone by someone you haven’t met yet or made eye contact with... I feel very guilty.”

Providers suggested that it took special effort to overcome these barriers and establish a therapeutic relationship after telephone counseling. However, the need to protect patients from burdensome and needless trips to the clinic outweighed these challenges. Overall, providers found compliance with the waiting period and the counseling process to be “onerous,” “frustrating,” “insulting,” and “draining,” as they attempted to shield patients from both the practical and emotional effects of HB 854.

Abortion providers and the public health impact of US abortion laws

There are multiple reasons why abortion providers have often been left out of public health conversations on abortion. First, as we described earlier, the historical legacy of *Planned Parenthood v. Casey* has directed challenges of abortion restrictions toward establishing an undue burden for patients. Consequently, this legal standard has dominated much public debate and understanding (Borgmann & Jones, 2000; Luna & Luker, 2013). Yet when an abortion provider successfully navigates new regulations and continues to provide care, it is her invisible labor and clinical adaptations that prevent a restrictive law from imposing undue burden. While this invisible labor mitigates public health concerns about patient

access to abortion services, the strain on the abortion workforce may not be recognized as a public health problem in its own right.

Focusing on abortion patients rather than abortion providers is also compelling for sociopolitical reasons. Abortion providers have often been vilified in popular media representations of the US “abortion wars.” While providers, scholars, and advocates have worked hard to dispel such myths, highlighting the empathy and compassion that necessarily underlie abortion care (Freedman, Landy, & Steinauer, 2010; Harris, 2012; Joffe, 1995), a focus on patient-level access barriers avoids the controversy that swirls around public representations of abortion providers themselves. Challenging abortion laws by focusing on patient-level impacts may thus be an easier case for reproductive rights advocates to make.

The research-practitioner nexus is not exempt from this logic, and may be complicit in the neglect of provider-level impacts in studies of abortion restrictions. As a relevant example, consider the response of one peer reviewer to an early draft of one of our articles. This reviewer urged us to reframe our article to focus on the impacts of HB 854 on patients, out of concern for the possible political repercussions of portraying providers as worried about the increased costs associated with the law. Given the stigmatized nature of abortion work, and the ongoing and increasing burden of abortion legislation, we are concerned about the unintended consequences of silencing conversations about the challenges of abortion provision in the US (Harris, Martin, Debbink, & Hassinger, 2013)—financial, emotional, or otherwise.

In addition to these legal, historical, and sociopolitical reasons why providers have often been left out of public health discussions of abortion, another possible explanation exists: because much of the public health field is ideologically aligned with improving the health of vulnerable populations, public health researchers and practitioners may be inclined to focus on structural interventions to enhance women’s access. Thus, when they hear that new abortion restrictions have resulted in increased barriers to care, they might ask what providers can do to connect women to abortion services more quickly and easily. This is certainly a reasonable response and aligns with providers’ own actions—our findings on the responses of North Carolina abortion providers to new legislation demonstrate that preservation of access motivated the majority of administrative and clinical adaptations. However, the expectation that providers can continue to respond to new challenges indefinitely is not realistic. There must be recognition of the limits to what overburdened and under-resourced providers can do. To the extent that legal challenges to abortion restrictions have focused on establishing an undue burden on patients, these legal challenges may obscure the substantial, burdensome, and uncompensated work performed by abortion providers to shield patients from the potential effects of these laws.

Such work is more than inconvenient—it makes it ever more difficult for abortion providers to deliver high quality care. As one male physician at an academic hospital-based practice noted, “Already, people are hesitant to provide (abortion) services to patients. It’s already a challenge just at baseline to have providers continue to do this and it just makes it more challenging for them to do it.” Many providers also expressed concern regarding the willingness of physicians who might be considering offering abortion services in the future.

In particular, they feared that for young physicians starting their careers, the extra burden on abortion providers may drive people away from an already under-resourced, yet critically needed, field of public health delivery.

Although *Roe v. Wade* legalized abortion in the US more than 40 years ago, abortion providers in many parts of the country continue to practice under considerable occupational stigma, threats to personal safety and wellbeing, and institutional barriers to offering abortion care (Harris, Debbink, Martin, & Hassinger, 2011; Harris et al., 2013; Joffe, 2014; Norris et al., 2011; O'Donnell, Weitz, & Freedman, 2011). New laws threaten to exacerbate these occupational challenges even further. While the stigma faced by abortion providers is well-documented, our work sheds light on an additional element: the invisible labor of abortion providers to minimize the burden on patients.

The invisible labor of abortion providers highlights the extent to which patient and provider burdens are deeply intertwined. As TRAP laws continue to increase, ever greater numbers of providers are practicing in restrictive environments. Many struggle to provide affordable, accessible, and compassionate care while complying with new laws. Therefore, understanding how abortion laws limit patient access *and* how providers work to maintain it in the face of political and legal challenges are both essential to understanding the public health impact of abortion laws. It is critical for public health practitioners, researchers, and scholars to attend to the multi-dimensionality of abortion laws and their implications for patients, providers, and society.

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Table 1

Characteristics of Study Participants

Characteristic	N (%)
Provider Professions	
Physician	17 (55%)
OB-Gyn	15 (88%)[a]
Family Medicine	2 (12%)[a]
Nurse	9 (29%)
Physician Assistant	1 (<1%)
Counselor	1 (<1%)
Administrator	3 (9%)
Practice Type	
Hospital Based	9 (29%)
Free-standing clinic	22 (71%)
Solo Practice	9 (41%)[b]
Group Practice/Clinic	13 (59%)[b]
Sex	
Female	23 (74%)
Male	8 (26%)
Years in practice providing abortion	
<10	16 (52%)
11–20	5 (16%)
21 – 35	5 (16%)
>35	5 (16%)

[a]% of physicians;

[b]% of free standing clinic