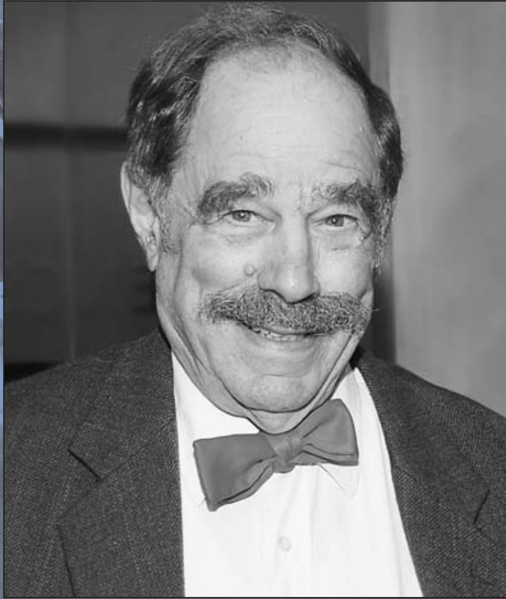
Physicians for Reproductive Choice and Health®

Presents



William K. Rashbaum, MD

in his own words

Introduction

As a young physician, Dr. William Kohlmann Rashbaum was regularly called upon to attend to women who had been seriously injured by illegal abortions. Since the legalization of abortion, he has done pregnancy terminations in New York City and has taught these procedures to thousands of medical students and residents, as well as practicing physicians around the country. He has also trained hundreds of physicians to handle the most complex and challenging cases that arise in the later stages of pregnancy and is responsible for training a large percentage of the people who do these procedures, not only in New York, but in surrounding states.

Dr. Rashbaum is a founding member of the Board of Directors of ***Physicians for Reproductive Choice and Health***®. He is also Associate Professor of Obstetrics and Gynecology at the Albert Einstein College of Medicine in New York City and is on the faculty of Cornell University School of Medicine. Dr. Rashbaum is still practicing as an Attending Obstetrician at Jacobi Hospital in the Bronx, Beth Israel Medical Center and New York Hospital in Manhattan.

Dr. Rashbaum was born in New York City in 1926, the son of an obstetrician/gynecologist and the grandson (on his mother's side) of the first fully-trained gynecologist in Louisiana. He graduated from New York University College of Medicine in 1951, and has been in practice since 1956. He did his internship at Bellevue Hospital and his residency in obstetrics and gynecology at Beth Israel and Mount Sinai Hospitals.

In His Own Words

Early Influences

My father knew I was interested in academic medicine, and he offered to get me an appointment at any of the medical schools in New York. But he didn't know anybody at Einstein, so I went to Einstein.

I was raised by a man who, the worst thing he could say about another physician was that he did abortions. I went into practice in 1956, and as

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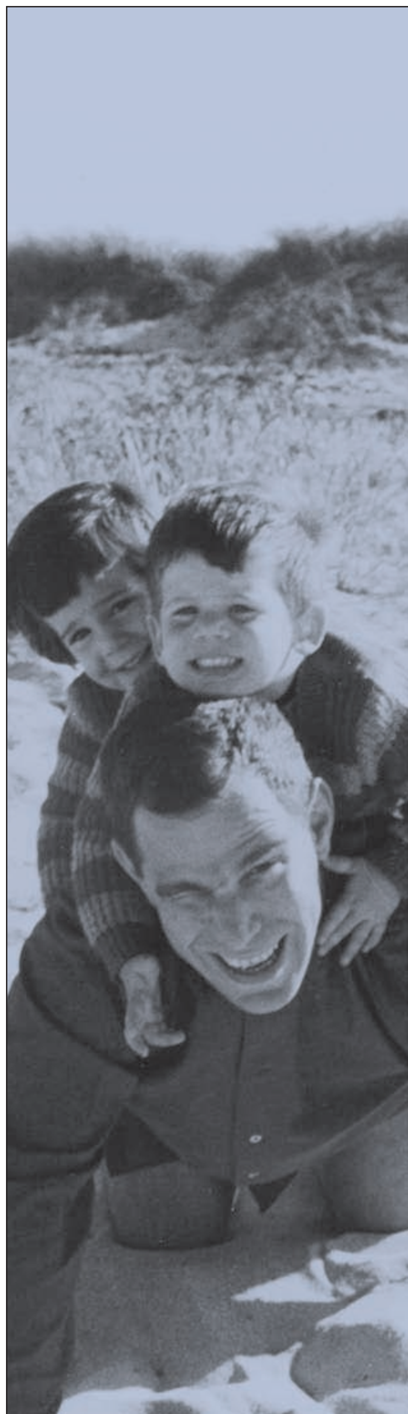
the practice grew my own patients would find themselves pregnant when it was not a good time for them to have a child. My father was terrified, because referring a patient for an illegal abortion was, according to him, an accessory to a felony. Although nobody was ever prosecuted for this, he was concerned that I would be arrested, tried and convicted. My father wasn’t against abortion; he was against breaking the law.

In the household I grew up in, the male parent was the decision-maker, or at least he was led to believe that he was the decision-maker. He would come down with his decision and his spouse—my mother—would either go along with it or sabotage it. Feminism back in the 1950s was certainly not the major force that it would become. And I maintain that women in our society are still not equal citizens to their male counterparts, and unless they fight to maintain their gains, they will lose them.

What Illegal Abortion Was Like

For more than 100 years—from the1860s to 1970—abortions were against the law. The largest cause of maternal deaths came from “criminal abortions,” as they were called. Maternity wards in big city hospitals were filled with women who had used coat hangers, catheters or corrosive substances in attempts to self-abort unwanted pregnancies.

Some women used the famous purple suppository, potassium permanganate, made in the shape of a coffin to denote its deadliness. The suppositories were placed in the vagina and would erode into a blood vessel, causing a hemorrhage. The women thought they were self-aborting, but instead they were hemorrhaging vaginally.



When I was a medical student and a resident, the gynecology wards were primarily filled with infected abortions, botched abortions and abortion complications. This was the tip of the iceberg, because we didn't know about the successful procedures, just the unsuccessful ones. But the tip of the iceberg was very visible, and the cost in terms of life, health and reproductive capacity was immense.

The wards were very different then. There was no such thing in those days as an Intensive Care Unit. There were 20, 30, 50-bed wards, usually two rows of beds, going the length of an extremely large room. And on the gynecological wards there were women who had incomplete abortions. So some of these women would be up in the front, close to the nurses, because they were close to death. And others would be in great pain because of abscesses, bleeding, or other forms of infection. They were paying with their fertility and their lives. Nobody made them have sex in the great majority of cases. I don't think anybody would argue about rape or incest. But peer pressure in the adolescent, the desire to please and the roaring hormones of adolescence, in many women, brought about their downfall.

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During my residency in the 1950s, a young woman was admitted with a history of vaginal bleeding. She was threatening to miscarry. In those days there were no Diagnoses Related Groups of Utilization Review Committees, so we were able to keep patients in the hospital for longer periods when needed. We also had no modern tools like ultrasound. She kept bleeding, and we kept seeing blood. We visited her on daily rounds, and there was always blood on her pad. When we looked inside there was never any blood in her vagina. We couldn’t understand it. We followed her for days. Then one morning a nurse found her sticking her finger with a stylette, squeezing it, and putting blood on her pad. It was all an attempt to get us to complete the abortion she was supposedly having. She was a very intelligent person, though unfortunately her ruse did not work. But that’s an example of the kind of desperation that was forced on women.

A tragic story that typified the days of the 1960s was when the wife of an ambassador from an African nation was rushed to me after she inserted a catheter inside her uterus to abort. It was a common method of emptying the uterus before suction. But this woman developed an overwhelming infection and went into renal shutdown.

What could be more horrific than death? More horrific than a patient with an abdominal and pelvic cavity full of puss? More horrific than eight or ten children left without a mother? Women will always have abortions, as they

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always have, whether from the bark of a tree, or an incompetent, untrained health worker, or a trained health worker, or a physician, or a specialist, it matters not. When you make abortion illegal, you make it dangerous.

Referrals

I would refer patients. One of my mentors was Alan Guttmacher (the Alan Guttmacher Institute is named for him). He, one of his associates and I kept a rotating file of working abortionists.

On occasion the police would tell the abortionists, “You’ll have to stop working now because we’re getting a lot of pressure.” And we would have to consult one another for who was available to take care of our patients. Mostly these were patients of means who could travel and who could afford to pay the medical costs. The poorer patients were left to the people who either knew what they were doing or didn’t know what they were doing, and, of course, in these situations the toll was a great deal higher.

There were some excellent people and there were some very unscrupulous people doing procedures. There was one in Havana and one in New York who had notorious reputations for abusing their patients. There were also abortionists in Puerto Rico to whom we sent patients. We heard that women who went down there would pay $500 and be forced to commit one or two sex acts. We still used such clinics, but only when we were desperate, and the patients were warned.

This is the kind of thing that went on in the time of criminal abortion. The best-trained people doing abortions were physicians. The price of a doctor-generated abortion was considerably more than that of a less well-trained

person doing the procedure, but the risks to both the patient and the performer were significant.

Secrecy was terribly important. People went to tremendous lengths to make sure that the patient was who she said she was, that nobody else was involved in this, that there weren't going to be law officers breaking into the middle of the procedure to arrest the provider. Theoretically (although I don't think this was ever prosecuted), the patient having the procedure was also committing a crime. The patient went knowing that it was illegal, knowing that it was dangerous, knowing that the wards of hospitals (particularly the municipal hospitals in New York City) were full of botched abortions and infected abortions. Patients would frequently lose their lives, or they would lose their fertility.

There was a doctor in Jersey City who used to work out of a telephone booth between five and six PM each night. The patients would call him, and he would send over a limousine. The limo would pick them up and take them to a back alley place where the procedures were done. No anesthesia, no sedation.

There was a pediatrician from Jersey—he did illegal, criminal abortions. He was a nice man—very empathetic. Once he had a school principal he tried to abort, but he couldn't complete the procedure so he sent her to me. When I examined her, I found that she had a large ovarian cyst that had been confusing him—he had been trying to abort her by doing a Dilation and Curettage on the ovarian cyst.

She had insurance so I tried to get her into the hospital. But in those days Blue Cross would only pay such benefits to the spouse of the contract holder. Actuarially speaking, Blue Cross maintained, only the spouse of a contract holder could get pregnant. Single women could not get pregnant—still speaking actuarially. This was the official basis for decisions.

But this woman was single. We admitted her to the hospital with the diagnosis of a twisted ovarian cyst, which wasn't really twisted, but we were able to remove the cyst and then complete the abortion.

A year or two later, the same doctor called me and said, "Dr. Rashbaum, I have a problem. I think I removed a bit of small intestine."

"What did you do with it?" I asked.

"It's in the bucket, doc," he said. "I think I may give her a shot of Demerol

and tell her to come back this afternoon."

I told him to put the specimen in something and send it and the patient to my office. A few hours later I was busy in my office when the bell rang. At the door was a uniformed chauffer.

"Can I help you?" I asked.

"I'm from Dr. So and So's office in New Jersey."

"Where's the patient?"

"She's in the car, doc."

Outside I found a seven-passenger Cadillac with the hood up on a hot, humid day. A middle aged woman was sitting in the back.

Again, I asked where the patient was. The chauffer opened the door with a flourish, and there lying on the floor of the car where the jump seats were folded was the patient. I took her pulse; it was strong. Next to her was a paper bag. I left her in the car and went to my office to examine the bag. Inside was her small intestine. This guy from New Jersey—usually a competent and experienced man—had panicked. He had perforated the uterus and pulled down bowel, thinking it was the umbilical cord. He had taken a pair of scissors and snipped. We saved her uterus and she survived.

The police later came looking for me. I hadn't done anything illegal, but I wasn't about to go to jail for this man. The lady in the car was the patient's aunt, and she hired an attorney who had been an assistant D.A. and kept the police at bay. The young woman was very sick in the hospital for weeks before she went home.

There were two occasions where I initiated terminations. These were people who I was close to, who consulted with me and made it clear that their circumstances were such that pregnancy was an impossible situation. I did endometrial biopsies and told them that I was fairly certain that they had pregnancies that would not continue. I did not charge for those visits. The two are as clear in my mind today as they were 40 years ago. I did a perfectly acceptable procedure and I didn't tell anybody what I was doing. I did it because they had so obviously, so carefully thought out this decision with their husbands. They both came to me with their partners, and there was complete autonomy of opinion with the couples. I was not making any decisions here. I was just implementing their decisions.

These two times that I did initiate a termination, I did it surreptitiously. I would have denied doing it. So obviously there was a lot of fear present. And if I did it for those two, how come I didn't do it for others? I don't know.

Dr. Spencer

My father was in military service during World War I, and told me the story of a surgeon in his unit, a man from Pennsylvania by the name of Spencer. Dad said he was the finest surgeon he had ever observed. Everybody knew about Dr. Spencer in the 1940s, 1950s and 1960s. He had had a daughter who was inadvertently killed by a criminal abortion, and he decided he would try to help prevent unnecessary death.

Spencer worked in a small town north of Lancaster, Pennsylvania. He would do an abortion for $100—cheap in those days of $500 and $1,000 fees. Dr. Spencer would also give his patients $20 to $30 of antibiotics and other drugs. He was truly a person who acted upon what he believed in: the principle of reproductive freedom.

I remember calling him once long distance to ask his advice. It was in the days before automatic dialing. I spoke with the long distance operator outside of Philadelphia when there was a continued no-answer to my call.

"Oh," she said. "They don't work on weekends. They're in Monday through Friday."

Everybody knew about Dr. Spencer. And everybody knew what Dr. Spencer did. The state police knew about him, and in fact protected him because he would take care of their daughters and wives when there was an unwanted pregnancy.

A schoolteacher from New York went to Spencer for an abortion. Post-op she still retained tissue, so it was an incomplete abortion—still today an acceptable complication of pregnancy termination and not an uncommon sequela of abortion in the 1950s and 1960s. But this woman became enraged and notified the authorities, insisting that Dr. Spencer be prosecuted. He was arrested, tried, convicted and released. He went right back to work, and remained very well known throughout the Northeast.

I guess he had more guts than I did.

The Early Years of Legal Abortion in New York: The Abortion Mecca

There were hospital abortion committees. And when the New York law passed [in 1970, three years before ***Roe vs. Wade***], the committees just became a joke. The law passed, but it didn't go into effect for some time. So we had forms: this blank age, blank race, female, whose last menstrual period was blank, is suffering from depression or something else. This pregnancy with blank complications threatens her life, her health, whatever. And it was just fill in the blanks. It was just a caricature. The great majority of these blank-blank-blanks were not true. It was just biding time until the law was in effect. I've never understood why they had such a long delay period.

Occasionally someone would get turned down. I remember one woman who was turned down who left and had a criminal abortion. This was a lady who had two bona fide suicide gestures and one bona fide homicidal gesture against her one child. And she wound up killing herself.

When the New York law legalizing abortion went into effect, I started working at the original Hale Harvey Clinic. Hale Harvey was a physician from New Orleans who I believe lost his license in Louisiana and migrated to New York, where he opened the first large-scale abortion clinic. And for several years New York City was the abortion Mecca of the world, and patients came by the planeload, the busload and the trainload every week to have their unwanted pregnancies terminated. The larger clinics used to send emissaries to the airports and to the bus stations, and there were services that chartered buses.

I suppose the funniest story happened in the early 1970s. One Saturday, it was especially busy in the best clinic functioning in New York. The waiting room was filled with people from all over. Suddenly there was the tremendous sound of screaming and shouting. A man had brought his girlfriend from Tennessee, and there in the waiting room he found his wife and her boyfriend.

Prior to the late 1960s, an abortion was a much bloodier and a much more dangerous procedure than it is today. When we first started doing legal abortions in New York City, the suction machine was a pump attached to a Dixie cup, with the top held on with rubber bands. Shortly thereafter, the more efficient and sophisticated suction machines were

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invented. In the early 1970s there were a number of deaths from the suction machine. If connected incorrectly the machine would blow instead of suction, causing some patients to die of air embolus. This is no longer possible, as the machines are now made in such a way that suction cannot be reversed.

When the law first changed, none of us knew what we were doing. In our first years we thought four to seven major complications in 100 cases were acceptable. Now more than one or two in 1,000 is not acceptable.

We didn't really know how to do abortions. We thought we did, but we didn't. We learned as we went along. When we had done 50 abortions, we thought we were experts. When we had done 100, we knew we were experts. By the time we had done 500 we were more humble. By the time we had done 1,000 we knew that we still had a lot to learn. And now that we have done maybe 35-to-40,000 first trimesters and 16,000 second trimesters, we realize we are still learning. Every one is just a little bit different.

Abortion Today

Many gynecologists felt that if we were going to spend our lives dealing with diseases peculiar to women or conditions peculiar to women, that it would be unfair to limit our activities to those women who were squeaky clean, so to speak. Feminism was becoming ascendant. If you're going to practice medicine that is dealing solely with the care of women, you have to take care of the less popular problems as well. In many other branches of medicine you lose and you lose and you lose, whether it be geriatric medicine, where everybody dies without too many years passing, or brain

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surgery, where the recovery rate is less favorable. With obstetrics, you almost always win, but the situations that women deal with are not always quite that joyous.

Abortion still carries a stigma in our society. Until 1970 it was considered a felony. It is also judged immoral by many, and what people deem as moral does not change. Morality doesn’t change because the law changes.

Many doctors today are reluctant to get involved. Protests are violent, and assassinations are not uncommon. Right to Life fanatics have not been silenced, and in fact under the Bush Administration they gain in strength and public acceptance. Their agitation continues as they raise money to continue their violence—and they are substantially better organized and funded than those who believe in freedom of choice for individuals. What the Right is saying, in essence, is that women must not control their reproductive lives; they must remain chattel. The majority of anti-choice picketers one sees are men, and not young men. And the women picketers are middle-aged women, beyond childbearing age. Tremendous damage was done to women before the current legal situation existed, and to go back to those days is unthinkable. The Right Wing would sacrifice women because they feel that abortion is tantamount to murder.

Today’s young women have never lived in a time when abortion wasn’t freely available and relatively inexpensive. I think that to go back to pre ***Roe vs. Wade*** is, to a certain degree, to re-institute slavery. To go back to the pre ***Roe vs. Wade*** era would be to go back to treating women as a piece of property. With the advances that contraceptives and ***Roe*** represent to women, it would be unthinkable.

We must train more physicians in these procedures as well as allow mid-level clinicians to be trained to provide early abortion services. Who will suffer if

more providers are not trained? The poor, mostly. I have seen women from lower socio-economic groups who have had multiple abortions. And I have seen the emotional and physical pain they were subjected to. I have seen that it is always a difficult, wrenching decision to make. In these situations, there is rarely a woman post-op who doesn't wake up crying. It is always a situation filled with conflicting decisions, and it is never easy.

The epidemic in teenage pregnancy shows us how volatile adolescents are and reminds us that if you're in poverty where you can't get an education or a job or decent housing, what is left? Even if you're incompetent, you get a baby to love and who theoretically gives back love. Does it make sense with the facts? Absolutely not. But is it real to young adolescent girls? Absolutely.

The way ob/gyns calculate duration of pregnancy is nuts. But there's a reason for it. The first day of the last menstrual period is 280 days from term, or 12 lunar months. So this is why women get so confused, because it doesn't make sense. But that's the way we figure it.

Counseling patients is important and difficult. It's also very time-consuming. Most practices see four or more patients an hour; we can only schedule two an hour. If a woman has never had a baby, whether she is having a voluntary termination or an indicated one, she needs a great deal of time to process her complicated emotions.

With medically indicated termination it's much more painful for the woman than her partner. Men by and large mourn more quickly than women, put it behind them and don't go back to it. Of course it is also not their bodies that are gravid. They haven't had a fetus inside them for four to six months, felt the kicking and now the loss of this creation of themselves. It is not qualitatively the same loss as a child, a spouse, a parent or a sibling, but it is a real loss for a woman.

Women do not enter into the decision to terminate a pregnancy lightly. Yes, there are women who use abortion as a method of birth control, and yes, they are rarer than hen's teeth. My office is full of women having medically indicated procedures, and the grief, pain, doubt and guilt that these women exhibit can only bring forth empathy, caring and gentleness. These are frequently fetuses that can't live or fetuses that are badly, badly defective physically or mentally. There are so many women today who tend

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to delay their childbearing until much later. And the incidence of problems is probably higher, so the toll is somewhat greater. And if a woman is 42, 43 years of age when she loses a pregnancy, her prognosis for a healthy pregnancy is certainly much more grim than a woman of 18 or 20 or 25.

Whether she aborts or doesn’t abort, she’s going to have a lot of regrets about the decision she makes. If she aborts she’s going to feel guilty, and if she doesn’t abort, every time there’s any conflict she’ll think, “If it wasn’t for this little bastard I wouldn’t be here.” So it’s unanswerable. But I do think that it’s terribly important that this decision not be made by fat, middle-aged men sitting in their ivory tower.

The anti-abortion movement has attacked and in some cases killed doctors. David Gunn was killed. Barnet Slepian was killed. George Tiller was shot in both arms. It is almost impossible to protect oneself from the fanatical crazies who declare war on human beings. Many of us have been forced to look into personal security. Some have been advised to wear a bullet-proof vest. We are frightened, yes, and we try to keep a low profile.

We live with the hope that common sense and compassion will triumph in the abortion issue. Our goal is to provide the best medical care, respect individual freedom and protect physical and emotional health. That has always been our goal.

PRCH

PRCH dates back to when Senators John East and Jesse Helms were trying to pass a constitutional amendment. A group of five or six doctors in New York City got together because we felt that physicians were not doing their part to fight the amendment. And we went to Al Moran, who was then the head of Planned Parenthood of New York City, and asked what he thought we should do. He recommended that we start a physicians' organization.

At PRCH we believe that every pregnancy should be a wanted pregnancy. So that includes contraception and trying to keep the practice of medicine in the hands of the practitioners of medicine. Some of the most egregious problems are those generated by legislators trying to make themselves popular with what they think is the conservative majority. Politicians have an objective, and often, the objective has nothing to do with good medical practice. Physicians carry a certain degree of credibility, and with a political issue, their credibility is not in question.

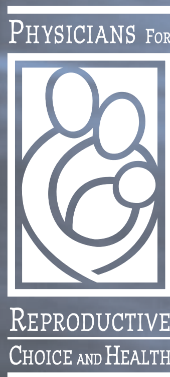
PRCH is the only physicians' organization solely concerned with reproductive freedom. It is not a deliverer of services, such as Planned Parenthood, and it is not a lobbying group. It is a group of physicians who are interested in the public health and the reproductive rights aspects of obstetrics and gynecology.

I don't think that we can afford to rest on our laurels. I think that to have a federal congress that can pass a law like it did this year and a president who will sign that law certainly means the work is not done. I think if you don't keep moving forward you're moving backwards. I would like to see a number of the organizations working on reproductive freedom form a coalition.

Legacy

I think I'm very fortunate. I think my legacy is what I would like it to be. When I was sick, I got calls from people I had trained whom I hadn't heard from in years. They had heard I was ill and they wanted to wish me well. I got a tremendous number of calls and the recognition that what I had to offer was being used.

The mission of *Physicians for Reproductive Choice and Health*® (PRCH) is to enable concerned physicians to take a more active and visible role in support of universal reproductive health. PRCH is dedicated to ensuring that all people have the knowledge, equal access to quality services and freedom of choice to make their own reproductive health decisions.



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