



# BRIDGING THE GAP BETWEEN ABORTION TRAINING AND ABORTION PROVISION

Recommendations from a National Symposium

New York City

October 23, 2000

NATIONAL ABORTION FEDERATION

PLANNED PARENTHOOD OF NEW YORK CITY

CONSORTIUM OF PLANNED PARENTHOOD ABORTION PROVIDERS

ACCESS PROJECT



## SYMPOSIUM ORGANIZING COMMITTEE\*

Rene Almeling  
National Abortion Federation  
Washington, DC

Vicki Breitbart, EdD, MSW  
Planned Parenthood of New York City  
New York, NY

Linda Prine, MD  
The Access Project  
New York, NY

Lynne Randall, MPH  
CAPS Project, Planned Parenthood  
Federation of America  
Atlanta, GA

## SYMPOSIUM FACILITATOR\*

Susan Dudley, PhD  
National Abortion Federation  
Washington, DC

## SYMPOSIUM PARTICIPANTS\*

Rachel Atkins, PA  
Planned Parenthood of New England  
Williston, VT

Traci Baird  
Ipas  
Chapel Hill, NC

Sven Becker, MD  
Johns Hopkins University  
Baltimore, MD

Lynn Borgatta, MD  
Boston Medical Center  
Boston, MA

Anne R. Davis, MD  
Columbia University  
New York, NY

Joan Fleischman, MD  
Access Project  
New York, NY

Patricia Glowa, MD  
Community Health Center  
Hanover, NH

Emily Godfrey, MD  
University of Rochester  
Rochester, NY

Marji Gold, MD  
Montefiore Residency Program  
Yonkers, NY

Fred Hopkins, MD  
Planned Parenthood  
San Diego, CA

Carole Joffe, PhD  
University of California, Davis  
Davis, CA

Herbert C. Jones, MD  
University of Virginia  
Charlottesville, VA

Annie Keating  
Physicians for Reproductive Choice and  
Health  
New York, NY

---

\*Titles and affiliations at the time of the Symposium

Mark Nichols, MD  
Oregon Health Sciences University  
Portland, OR

Deborah Oyer, MD  
Aurora Medical Services  
Seattle, WA

Maureen Paul, MD, MPH  
Planned Parenthood League of  
Massachusetts  
Boston, MA

Murray Pelta, MD  
Planned Parenthood of Chicago  
Chicago, IL

Pablo Rodriguez, MD  
Planned Parenthood of Rhode Island  
Pawtucket, RI

Wayne Shields  
Association of Reproductive Health  
Professionals  
Washington, DC

Felicia Stewart, MD  
University of California, San Francisco  
San Francisco, CA

Jini Tanenhaus, PA-C  
Planned Parenthood of New York City  
New York, NY

George Tiller, MD  
Women's Health Care Services  
Wichita, KS

Tracy Weitz, MPA  
University of California, San Francisco  
San Francisco, CA

Janet Young, PA  
Vermont Women's Health Center  
Burlington, VT

## SYMPOSIUM REPORT AUTHOR

Blakely Pomietto, MPH  
Residency Training Program Coordinator  
National Abortion Federation

# BRIDGING THE GAP BETWEEN ABORTION TRAINING AND ABORTION PROVISION

Recommendations from a National Symposium

New York City

October 23, 2000

In October 2000, the National Abortion Federation (NAF), Planned Parenthood of New York City (PPNYC), the Consortium of Planned Parenthood Abortion Providers (CAPS), and The Access Project convened a national symposium to discuss best practices in abortion training and to consider strategies to ensure that the resources invested in abortion training result in actual increases in the number of qualified abortion providers.

The symposium focused on evaluating progress to date in a wide range of formal and informal training programs, and considering future directions for training. It provided the first opportunity for providers of abortion training and services to come together to develop strategies for translating abortion training into positive, personal commitments to service delivery on the part of trainees, and equipping trainees with skills for navigating and overcoming the barriers to becoming abortion providers.

Since the Symposium was convened, many of the participating organizations and individuals have made strides towards incorporating the recommendations generated at the Symposium into their work. For instance, we have seen the development of new and innovative curricula, the emergence of new systems and venues to facilitate networking and sharing of experience and expertise, and specialty-specific resources, training, and programming. At the same time, we are still confronting and working to address the challenges of translating training into practice identified at the Symposium. We present the key findings and recommendations of the Symposium participants in this report as a resource for organizations and individuals engaged in the important work of abortion training and abortion service provision as we continue to collaborate and seek creative and meaningful solutions that ensure access to high quality abortion services for women who need them.



© 2005 National Abortion Federation  
1755 Massachusetts Avenue, NW  
Suite 600  
Washington, DC 20036

phone: 202-667-5881 • fax: 202-667-5881 • [naf@prochoice.org](mailto:naf@prochoice.org) • [www.prochoice.org](http://www.prochoice.org)

## TABLE OF CONTENTS

SUMMARY OF FINDINGS AND RECOMMENDATIONS.....	5
SETTING THE CONTEXT .....	9
FINDING I: VALUING ABORTION SERVICES .....	10
FINDING II: REVISING TRAINING RESOURCES .....	20
FINDING III: CONNECTING WITH PATIENTS .....	27
FINDING IV: DEVELOPING STRATEGIES TO SUPPORT ABORTION TRAINEES & TRAINERS .....	31
CONCLUSION .....	38
REFERENCES CITED .....	39

## SUMMARY of FINDINGS and RECOMMENDATIONS

In October 1990, the National Abortion Federation (NAF), along with the American College of Obstetricians and Gynecologists (ACOG), convened a national symposium to explore the shortage of physicians willing to provide abortions and to make recommendations to correct the problem. Ten years later, however, despite improved and increased training opportunities, the expected reversal in the trend of decreasing ranks of abortion providers had not materialized. It became clear that if training efforts were to achieve the necessary public health goal of ensuring the availability of providers to care for the women who need abortion services, they would need to be taken to “the next level.” Such training must ensure that trainees will adopt a personal commitment to provide abortion services to their patients. In order to put such a commitment into practice, training must also equip trainees with the skills to navigate and overcome some of the more practical barriers to the delivery of abortion services (i.e. malpractice insurance, insurance reimbursement, pressure from colleagues and family, etc.).

In 1996, there were 2,042 abortion providers in the U.S., compared with 2,380 providers in 1992, a 14% decline. Similarly, in 1996, only 703 hospitals reported providing abortion services – almost 18% fewer than in 1992 (Henshaw, 1998). During that same time period, however, the number of abortions provided in the United States declined by just over 10% (Henshaw, 1998). It was clear that the number of abortion providers remained inadequate compared to the need for services. In light of this fact, and on the heels of the U.S. Food and Drug Administration’s approval of mifepristone for early abortion, NAF, PPNYC, the CAPS Project, and The Access Project convened another national symposium in October of 2000 to consider best practices for making abortion training more effective, to address ways to expand the role of advanced practice clinicians in delivering abortion services, and to discuss ways to ensure that the resources spent on future training result in a direct increase in the number of qualified abortion providers. The Symposium participants’ key findings and recommendations are summarized here.

As the focus of the symposium was solely training and training-related issues, it is inevitable that segments of the discussion overlapped and/or returned full-circle to the original issue/question. As such, it is difficult to draw out discreet, independent findings and recommendations that do not overlap as well. The findings and recommendations outlined in this document have been organized to help the reader identify points of action and translate this information into programs and strategies to improve the effectiveness of abortion training.

### FINDING I: *VALUING ABORTION SERVICES*

Despite an apparent increase in the number of abortion training experiences available to medical students, residents, physicians, and other clinicians in the past 10 years, the Symposium participants find that a significant gap remains to be bridged between the trainee’s initial training experience and an actual long term commitment to providing abortion care.

### RECOMMENDATIONS:

- 1) Continue efforts to identify and implement creative means of infusing abortion training into medical school curricula, residency programs and advanced practice clinician training

programs where trainees gain their initial understanding of the professional obligations they will be expected to adopt.

- 2) Include an emphasis on the public health implications of laws or regulations that restrict access to safe, legal abortion in both didactic and clinical abortion training.
- 3) Integrate facilitated values clarification work around abortion and more commitment-building experiences into initial training, and devise follow-up processes or experiences that will sustain that commitment.
- 4) Promote dialogue among medical professionals at gatherings of all types (i.e. medical school symposia, grand rounds, and professional meetings) that will encourage understanding of the rewards and personal gratification of providing abortion services.

## **FINDING II: *REVISING ABORTION TRAINING RESOURCES***

Existing abortion training materials, curricula, and clinical experiences have appropriately emphasized development of technical skills. The Symposium participants find that a re-examination of the assumptions that guided the development of these materials is needed in order to facilitate production of a second generation of training resources that will add features to better motivate trainees to continue providing abortion services and equip them with the necessary skills and resources for navigating institutional, collegial, and other barriers.

### **RECOMMENDATIONS:**

- 1) Develop targeted strategies for training providers of both medical and surgical abortion among trainees in ob/gyn, family practice, pediatric and adolescent medicine, internal medicine, and emergency medicine, as well as advanced practice clinicians, that are both specialty-appropriate, and training-level appropriate.
- 2) Focus curriculum development efforts for both didactic and clinical training experiences on the creation of new, innovative, and adaptable training opportunities that can be tailored to meet the specific needs and experiences of individual trainees.
- 3) Ensure that training materials, curricula and experiences move beyond the technical and procedural aspects of abortion to include regulations and legal restrictions adopted by state and federal governments, billing and insurance reimbursement filing procedures, and other administrative issues. In addition, trainees need to be equipped with the skills for confronting and successfully overcoming the very real and practical barriers that can prohibit translating their training into the delivery of services, including institutional barriers, malpractice insurance, resistant attitudes from staff, colleagues, and/or family, and concerns about violence and harassment.
- 4) Develop specific competency assessment criteria to be used in determining when training of a provider is complete. These should include evaluation by patients and clinic staff, in addition

to technical mastery, so that evaluation is based on experience with the wider range of competencies needed to sustain commitment to abortion provision.

### **FINDING III: *CONNECTING WITH PATIENTS***

Delivery of quality abortion care includes more than exercising a technical medical skill. Abortion service provision is an area of medicine unique in the immediacy and intensity of feelings it evokes on the part of patients. The Symposium participants find that implementation of new ways to keep trainees connected to their patients, and thereby the emotional rewards of doing this work, is critical.

#### **RECOMMENDATIONS:**

- 1) Promote among trainees an orientation to “care” by placing increased emphasis on patient-centered models of care, including patient counseling and communication skills in provider training, and maintaining provider continuity in clinical settings (from intake through recovery and follow-up).
- 2) Ensure that listening and patient-communication skills are not only included in didactic training materials, but are emphasized in training experiences, so that the rewards and benefits that providers typically derive from direct contact in abortion services can be felt in personal and meaningful ways by trainees.
- 3) Expose trainees - - medical students, residents, and advanced practice clinicians - - to medical abortion services. Because the provision of medical abortion relies heavily on patient education and preparation, it offers important opportunities for connecting with patients. Further, as medical abortion becomes a service offered by a growing number of providers *over a range of specialty areas*, trainees should be exposed to the skills and systems for delivery of medical abortion services.

### **FINDING IV: *DEVELOPING STRATEGIES TO SUPPORT ABORTION TRAINEES AND TRAINERS***

Institutional concerns and resistance to providing abortions and abortion training, and especially to presenting this training in contexts outside of the technical skills-building model, remain a significant concern. The Symposium participants find that there is a need for innovative advocacy efforts that will result in more supportive and productive institutional models for abortion training and subsequent abortion service delivery.

#### **RECOMMENDATIONS:**

- 1) Provide multifaceted support for institutions and clinics to work through the logistics of establishing an abortion training program, which can themselves serve as barriers to providing abortion services and training. Institutional issues may be different in different specialty areas, but typical concerns include cost and salary issues for clinical training, legal issues, and involvement of nursing and clinical staff.



- 2) Identify and overcome barriers for clinicians who want training, including peer supported resistance. Encourage and facilitate the development of advocacy roles specifically for medical students, training faculty, advanced practice clinicians and professional organizations. Encourage and cultivate new potential leaders in abortion service advocacy by bridging the gap for students leaving Medical Students for Choice and initiating their residency program training.
- 3) Continue efforts to promote the integration of mandatory abortion training into standard training in ob/gyn, and begin similar initiatives for family practice, pediatric/adolescent, internal and emergency medicine, and advanced practice clinician training programs. Not only will such training directly dispel misinformation, myths and misconceptions associated with abortion provision, but it will also equip providers with accurate information and experience to counsel and refer patients who need abortion care. Moreover, it will also teach the positive and rewarding aspects of providing abortions to women who need them.
- 4) Continue coalition-building work on behalf of advanced practice clinicians. A priority should be advocating for interpretation of or changes to existing laws to expand the role nurse practitioners, physician assistants, and nurse-midwives can play in the delivery of abortion services.
- 5) Explore and develop new models of abortion provision. To facilitate this process, assemble teams of abortion-provider consultants with expertise ranging from legal issues to security concerns to post-training practical and institutional obstacles to serve as resources, answer questions, and provide workshops for new providers and/or clinics.
- 6) Continue essential efforts to educate the public about the competence and commitment of abortion providers.

## SETTING THE CONTEXT

Over the past two decades, abortion provision has become the province of an ever decreasing number of committed and determined clinicians, so that women outside of larger urban centers who need abortions have been forced to travel farther and endure greater difficulties in accessing this care. According to the Alan Guttmacher Institute, 87% of all U.S. counties had no identified abortion provider in 2000, and that number increased significantly – to 97% – in nonmetropolitan counties (Finer and Henshaw, 2003). In an attempt to alleviate this problem, pro-choice organizations, grassroots activists and abortion providers have worked to increase the availability of abortion training for residents and established clinicians.

In 1990, the National Abortion Federation (NAF) along with the American College of Obstetricians and Gynecologists (ACOG) convened a national symposium to discuss what was then a newly recognized shortage of abortion providers and make recommendations to address the problem (National Abortion Federation, 1991). Since that time, NAF – along with many allies, partners, and supporters – has made great strides in developing programs, influencing policy, and expanding abortion training opportunities to increase the ranks of abortion providers and to remedy this developing public health crisis. The 1990 symposium marked the beginning of an important reinvigoration of abortion training.

One important consequence was that in 1995 the Accreditation Council for Graduate Medical Education (ACGME) acknowledged that abortion training opportunities had dropped to a dangerous level and adopted clear new guidelines that explicitly set forth the expectation that abortion training would be available to all ob-gyn residents. A 1998 study of ob-gyn residency programs around the country provided some early data that cautiously suggest a possible increase in the number of programs providing abortion training. A follow-up symposium held in 1996 was also inspired by the 1990 meeting, this time focusing on the role that advanced practice clinicians (APCs) – such as physician assistants, nurse practitioners and nurse-midwives – can play in providing abortions (National Abortion Federation, 1997).

Despite the accelerated training efforts initiated since the first symposium in 1990, significant provider shortages, particularly outside of urban centers, remain. In 2000, 34% of women of reproductive age lived in counties without an abortion provider, and an additional 41% lived in counties without a large abortion provider (defined as a facility that provided 400 or more abortions per year) (Finer and Henshaw, 2003)\*. Although more training was taking place, it had not necessarily resulted in increased numbers of clinicians providing abortions. Building on the accomplishments since the 1990 symposium, in 2000 NAF, Planned Parenthood of New York City (PPNYC), the Consortium of Planned Parenthood Abortion Providers (CAPS), and The Access Project convened “Abortion Training: The Next Level.” This meeting brought together experienced abortion trainers to discuss best practices and to explore ways to build a commitment to abortion provision into effective abortion training.

---

\* Author’s Note: In this publication, the term “abortion provider” – or simply “provider” – means an individual. However, in the Finer and Henshaw data cited here (2003), a “provider” is defined as a site where abortions are performed. By this definition, several physicians providing abortions at one location would count as one provider; a health agency with several clinics would be counted as multiple providers. Unless otherwise noted, throughout the rest of this report, the term “provider” will refer to an individual.

“Abortion Training: The Next Level” gave abortion trainers an opportunity to assess what has worked to help counter the provider shortage, what has not worked, and what kinds of changes should be made to training protocols to ensure that abortion training effectively results in trainees incorporating abortion into their practice. Clearly characterizing “the next level” in training and finding ways to reach that next level are especially critical as the field faces new challenges, opportunities, technologies and medical advancements.

#### **FINDING I: *VALUING ABORTION SERVICES***

Despite an apparent increase in the number of abortion training experiences available to medical students, residents, physicians and other clinicians in the past 10 years, the Symposium participants find that a significant gap remains to be bridged between the trainee’s initial training experience and an actual long term commitment to providing abortion care.

#### **BACKGROUND:**

One of three key findings from the 1990 symposium was that obstetrics and gynecology residency programs fall short of their responsibility to train physicians in abortion and contraceptive services. From that finding recommendations were developed not only to increase the availability of abortion training opportunities, but also to develop appropriate training resources. In the years since that meeting, advocacy and medical groups have addressed this problem with the introduction of a wide range of new training opportunities that resulted in significant improvements in the number and variety of abortion training experiences available. These include:

- In 1992, the University of California at San Francisco initiated a fellowship program in Family Planning Clinical Care and Research at San Francisco General Hospital. These fellowships offer postgraduate training in abortion and family planning to ob/gyn and family practice residents. By 2000, the fellowship program included seven different sites around the country. In addition to offering high-level research opportunities, the fellowship provides fellows with the opportunity to work in an international setting, and to pursue either a Masters Degree in Public Health or a Masters of Science Degree.
- In 1993, NAF sponsored the founding of Medical Students for Choice (MSFC). MSFC began organizing medical students across the United States and Canada around the common goals of including abortion in medical school curricula, obtaining abortion training in residency programs, and finding support as future abortion providers. MSFC later incorporated as a separate entity, and boasts chapters on over 100 medical school campuses. A central focus of their work revolves around medical school curriculum reform to include accurate, objective, and comprehensive abortion information.
- Planned Parenthood of New York City established the Clinician Training Initiative (CTI) in 1993, to train ob/gyn residents in the provision of first trimester surgical abortion services. Over the next seven years, the CTI expanded to include family practice residents; began to train physician assistants (PAs) in abortion care; published an abortion training curriculum; and played a lead role in providing training in medical abortion.

- The American Medical Women's Association (AMWA) launched their Reproductive Health Initiative in 1993. Founded by a group of AMWA members interested in curriculum reform, the goal of this project is to build capacity within medical schools and other medical training institutions to provide reproductive health education and training. Out of this project developed the Reproductive Health Initiative Model Curriculum, a comprehensive curriculum for medical students, faculty, and other health care professionals alike.
- In 1995, NAF published and distributed a curriculum for didactic and clinical abortion training, *Clinical Training Curriculum in Abortion Practice*. Written by the foremost researchers and clinicians in the field, the curriculum offered 9 different modules, each specific to a different aspect of abortion care. As new technologies and standards of care evolved, new modules for the curriculum were developed to include medical abortion using mifepristone or methotrexate, manual vacuum aspiration, and values clarification. (The National Abortion Federation's *Clinical Training Curriculum in Abortion Practice* is included in the RHI Model Curriculum).
- In 1997, the National Abortion Federation acted on recommendations from the 1996 Symposium (focused on expanding the role of advanced practice clinicians in providing abortions) by initiating the development and organization of Clinicians for Choice (CFC). CFC is a national organization that works to educate, organize and support pro-choice physician assistants, nurse practitioners and nurse-midwives. Among CFC's goals are connecting advanced practice clinicians with abortion training opportunities, working with and supporting APC programs to increase didactic and clinical training in abortion and comprehensive reproductive health care, and facilitating the development of curricula and other abortion-training resources.
- In order to prepare and enable clinics to host resident trainees, NAF began offering technical assistance. This grew to include formal Residency Training Workshops that NAF began convening biennially in 1998. These workshops match representatives from clinics and nearby residency programs, and bring them together to facilitate the development of formal residency training partnerships. As of Spring 2000, 12 residency programs and 20 NAF member clinics had participated in Residency Training Workshops and begun working towards developing new abortion training opportunities.
- In 1999, the Center for Reproductive Health Research & Policy at the University of California at San Francisco organized the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning, designed to address the need for training in abortion and family planning within the academic community. The Kenneth J. Ryan Program serves to provide information about various abortion training models, identify residency programs either interested in starting or in improving their existing abortion training component, and facilitate the development of a formal residency rotation in abortion and family planning.
- The National Abortion Federation published the most comprehensive and authoritative textbook on abortion in 1999. *A Clinician's Guide to Medical and Surgical Abortion* covers all aspects of abortion care, ranging from patient preparation and informed consent, to medical

and surgical abortion techniques and aftercare, including the most scientific information and clinical expertise in abortion care.

- In anticipation of the approval of mifepristone for medical abortion in the United States, the National Abortion Federation launched the Medical Abortion Education Initiative in July 1999. NAF developed resources and programs for educating and preparing health care providers to offer medical abortion services. Included in these resources were a special supplement to the *American Journal of Obstetrics and Gynecology* in August of 2000, and a series of one-day, regional mifepristone seminars, conducted throughout the United States in collaboration with the Consortium of Planned Parenthood Abortion Providers (CAPS).
- In October, 1999, The Access Project received funding to expand women's access to reproductive choice by facilitating the integration of abortion provision into family medicine settings. In addition to collaborating with PPNYC's CTI to initiate training of family medicine physicians in mid-2000, the Access Project advocates for family physicians and other primary care practitioners to become early abortion providers, and facilitates the development of new sites for the delivery of and training in abortion care within family medicine.

In addition to the numerous training initiatives developed during the early 1990s, several key professional and educational organizations came forward with formal statements encouraging the widespread infusion of abortion training into existing educational experiences, including medical schools and ob/gyn residency programs. In January 1994, the Executive Board of ACOG released a formal statement, "To address the shortage of health care providers who perform abortions, the College encourages programs to train physicians and other licensed health care professionals to provide abortion services in a collaborative setting."

The 1995 revision to the ACGME requirements for abortion training in accredited obstetrics and gynecology residency programs - - another outgrowth of the 1990 symposium - - was crucial in providing an important impetus for positive curricular changes in those programs. The new standard evolved through a series of iterations, until a final version was adopted on July 31, 1995 for implementation beginning January 1, 1996:

"No program or resident with a religious or moral objection shall be required to provide training in or to perform induced abortions. Otherwise, access to experience with induced abortion must be part of residency education. Experience with management of complications of abortion must be provided to all residents. If a residency program has a religious, moral, or legal restriction that prohibits the residents from performing abortions within the institution, the program must ensure that the residents receive satisfactory education and experience in managing the complications of abortion. Furthermore, such residency programs (1) must not impede residents in the programs who do not have religious or moral objections from receiving education and experience in performing abortions at another institution and (2) must publicize such policy to all applicants to those residency programs" (Section V, A, 2, e).

The Association of Professors of Gynecology and Obstetrics (APGO) has also endorsed the ACGME position on abortion training in the 7<sup>th</sup> Edition of *Medical Student Educational Objectives*, which outlines the “knowledge, skills, and attitudes that ideally would be acquired during the obstetrics and gynecology clerkship by all students, regardless of their choice of medical specialties” (APGO, 1997). Included in “Unit 3 – Gynecology,” under “Section A – General Gynecology,” is Objective 37: Abortion:

“Rationale: Induced abortion is a reproductive option considered by some patients. Regardless of one’s personal views, the practitioner should be aware of the techniques, management, and complications of induced abortions.

The student will be able to list:

- A. Surgical and non-surgical pregnancy termination methods
- B. Potential complications of abortion, such as
  1. Hemorrhage
  2. Infection
- C. Psychological considerations of abortion”.

In 1999, the American Public Health Association (APHA) adopted a 24<sup>th</sup> abortion-related resolution, this time advocating for advanced practice clinicians as abortion providers. Citing numerous references supporting the competency and importance of advanced practice clinicians in delivering abortion care, the APHA “therefore

1. Supports the provision of first trimester surgical and medical abortion by appropriately trained NPs, CNMs, and PAs;
2. Supports efforts to overcome legal and regulatory obstacles which limit the participation of NPs, CNMs, and PAs in abortion;
3. Encourages NP, midwifery, and PA education and training programs to provide didactic and clinical training in abortion services, such as options counseling and pre-and post-abortion care, and in abortion techniques, for those who desire such training;
4. Urges the inclusion of NPs, CNMs, and PAs in the labeling of medical abortion pharmaceuticals; and
5. Urges health professionals to educate themselves, their colleagues, and the public about the skills of NPs, CNMs, and PAs and their competence to provide abortions” (APHA Policy Statement 9917).

Each of the efforts described above appears to have worked both individually and collectively in producing a new cohort of people clinically prepared to offer abortion services. One indicator of this success can be seen in a 1998 survey of accredited ob/gyn residency programs that found a significant increase in the reported availability of abortion training in those programs. Eighty-one percent (81%) of the programs reported offering first-trimester abortion training (46% reported doing so routinely), and 74% of programs reported offering second-trimester training (44% reported doing so routinely) (Almeling, Tews, Dudley, 2000). While the authors noted several factors that might have led to an unrealistic inflation of these numbers, the results are still suggestive of important increases from a similar 1991-1992 study showing 70% of residency programs offering first-trimester abortion training (12% reported doing so routinely), and 65% of programs offering second-trimester abortion training (7% reported doing so routinely) (MacKay and MacKay, 1995).

However, in the face of these successful attempts to increase abortion training opportunities, and expose more medical students and residents to abortion practice, the number of abortion providers in the United States has continued to decline. Between 1992 and 1996, the total number of abortion providers in the U.S. dropped 14%, with the greatest declines seen among hospitals (18%). In addition to fewer providers overall, the geographic distribution of the remaining providers continues to pose even greater barriers to access for women in nonmetropolitan areas. In 1996, 86% of all counties had no known abortion provider, while 95% of nonmetropolitan counties lacked an abortion provider (Henshaw, 1998).

#### RECOMMENDATIONS:

- 1) Continue efforts to identify and implement creative means of infusing abortion training into medical school curricula, residency programs and advanced practice clinician training programs where trainees gain their initial understanding of the professional obligations they will be expected to adopt.

The emergence of Medical Students for Choice and its efforts to reform medical school curricula have played a significant role in the effort to infuse objective and comprehensive abortion information into medical school programs.\* While they have achieved notable strides in medical school programs across the country, efforts to reform residency program curricula have met with minimal success. Instead, it is not uncommon for individual residents to attempt to seek out abortion training one by one, trying to squeeze it into their already tight schedules when they have elective opportunities.

The potentially critical influence and role a single individual can play in facilitating abortion training in a medical school or residency program should not be underestimated. A single faculty member who provides abortions - - if not abortion training - - can be the first impetus and influence to develop an abortion training component of the program. Likewise, a single faculty member who is staunchly and vocally opposed to abortion can be the largest and most difficult barrier to overcome.

In establishing a new abortion training program or opportunity where there previously was none, small steps may be the only option in the beginning. The Symposium participants make several suggestions for targeting residency programs. In particular:

- Training in the provision of abortion services - - both in didactic and clinical contexts - - should become part of professional expectations from the beginning in medical school and residency, so that it is not experienced as an optional “add on” later on in the program.

---

\* In 2002, Medical Students for Choice initiated the Curriculum Mapping Project (CMP), with the goals of documenting the current status of reproductive health education in medical schools in the United States and Canada, identifying priority areas for action, developing strategies for effective curriculum reform, and tracking reform efforts longitudinally. The CMP survey was pilot tested in September 2002, and expanded to all medical schools with an active MSFC chapter in December 2003. Results of the CMP will be available after April 2003.

- Abortion training must be conceptualized not as a *task* but as a *process* with continuing exposure. It is incumbent on current providers and advocates of abortion training to make this process easy for residency programs to incorporate.
- Starting small may be necessary to build the framework for a full-fledged abortion training program. This could include such measures as offering elective seminars (small groups) to address values clarification through lecture, discussion and various exercises; building into existing courses, curricula and programs self-learning opportunities that faculty can encourage and facilitate; encouraging students to interview faculty in the program regarding their feelings on abortion; engaging pro-choice clinicians (including advanced practice clinicians) as speakers in classes and special lectures; and educating residents, established physicians and other health care professionals through Grand Rounds.
- Outpatient residency clinic settings offer an important opportunity to integrate abortion training in a context that serves to mainstream abortion services into primary care medicine, and should not be overlooked.
- Clinics that provide abortions can “build a bridge” to a residency program (and future abortion training program) by appointing a faculty member to their Board or medical staff.
- Creating a new program requires not only support from the physicians in the residency program, but also the support of nursing and non-nursing staff. This holds true not only in residency programs, but also in established private practices that are moving towards offering abortion services.
- As discussed above, several fellowship opportunities have been developed. Another approach could be to create a new national program composed of several regional training sites, each of which hosts 3-6 month post-residency fellowships. These fellowships should be designed around furthering the abortion training experience, working to cultivate the long-term commitment of fellows to abortion provision, and building respect for both the work of providing abortions and the clinicians who provide them.
- Specific efforts should be made to recruit trainees who are likely to provide abortion services upon completion of training, or who have demonstrated a commitment to provision.
- As the scope of practice of advanced practice clinicians continues to increase, both didactic and clinical abortion training experiences should be incorporated into physician assistant, nurse practitioner, and nurse-midwife training programs.

The 1990 symposium recommended integration of abortion proficiency assessments into board examinations and residency reviews. To date, this has not been successfully implemented. As described by Carolyn Westhoff, MD, MSc, in 1994, “Written and oral



board examinations do not include questions about abortion. While board certification in obstetrics/gynecology is contingent, in part, on presenting evidence of an adequate surgical caseload, abortion cases are not required” (Westhoff, 1994). The absence of training requirements sends a clear message implying that such training is not important, enabling residents to avoid learning abortion techniques and thereby limiting their ability to fully address the needs of their female patients.

- 2) Include an emphasis on the public health implications of laws or regulations that restrict access to safe, legal abortion in didactic and clinical abortion training.

Hand-in-hand with mainstreaming abortion training is normalizing abortion care as both a public health issue and a part of a complete health care system. Excluding abortion information, discussion, education and training from medical school curricula and residency programs has only served to marginalize abortion work and the providers committed to providing abortion services. From a public health perspective, access to safe, legal abortion is critical.

- On January 22, 1973, the Supreme Court decision in *Roe v. Wade* legalized abortion in the U.S. In 1972, the Center for Disease Control reported 41 deaths resulting from illegal abortion procedures. However, in 1973, only 22 such deaths were reported, and only 7 in 1974, a decrease of more than 80 percent between 1972 and 1974 (Gold, 1990).\*
- Parental notification or consent requirements for teenage women seeking abortions make abortions more difficult to obtain, and therefore result in more unwanted pregnancies carried to term among adolescent women (Lichter, McLaughlin, Ribar, 1998). Research also shows that state parental involvement statutes result in delayed access to abortion services (Carter and Klerman, 1986; Yate and Pliner, 1988), and later abortions carry with them increased risks of complications in comparison to earlier abortions.
- The inaccessibility of services - - including the distance a woman must travel to an abortion provider, the gestation limits of the provider(s) to whom she has access, and her ability to pay for services - - leads to fewer abortions and later abortions (Shelton, Brann, Schulz, 1976; Henshaw, 1995), again with their incumbent increased risk in comparison to earlier abortions.

Understanding the public health context of abortion includes understanding the social costs incurred when some women are not prepared but are forced to bear children, or when parents are unable to support their children. The availability of Medicaid funding to pay for abortion services would make abortion accessible to women with unwanted pregnancies who otherwise would have carried to term. However, the Hyde Amendment restricts federal Medicaid funding of abortion only to cases of rape, incest, and life endangerment. Only slightly over one-third of states provide funding for abortion under additional circumstances using state

---

\* The CDC reported figure of 41 deaths from illegal abortion is almost surely a gross underestimate, even though there were a few places where legal abortions were available at that time. CDC estimates are low by definition, as they reflect only those abortion-related deaths resulting from the limited number of legal procedures, or those from illegal *but acknowledged* abortions.

Medicaid funding. A 1980 study of the impact of federal funding restrictions found that 18-23% of women on Medicaid who would prefer to have an abortion instead carried their pregnancies to term in the absence of available Medicaid abortion funding (Trussell et al, 1980).

The issue of adolescent pregnancy provides a clear example of abortion as a matter of public health. According to the Alan Guttmacher Institute, nearly 1 million adolescent women become pregnant each year. Of those 1 million pregnancies, approximately 30% end in abortion, and more than half (56%) end in birth (AGI, 1999). Those unplanned adolescent pregnancies that end in abortion save society the economic, public health, and social costs that could have been incurred, including higher risk of adverse birth outcomes, low birthweight, infant mortality, reduced educational attainment, and (thereby) limited future employment prospects and earnings potential (Federal Interagency Forum on Child and Family Statistics, 2000). The availability of and access to abortion, then, carries specific impacts on women, children, and the society of which they are a part. Out of desperation, some women who cannot afford an abortion will attempt to induce one themselves; this is not only medically very dangerous, but is likely to be unsuccessful and result in further delays before seeking a safe abortion, at a greater cost financially, and with a greater potential for complications.

- 3) Integrate facilitated values clarification work around abortion and more commitment-building experiences into initial training, and devise follow-up processes or experiences that will sustain that commitment.

The form that such exercises should take remains unclear because no published research has systematically explored what motivates a physician to make a commitment to providing abortion services. Therefore, Symposium participants suggest three avenues for exploring this issue:

- *Incorporate facilitated values clarification work around abortion into both didactic and clinical training experiences.* Abortion training can be a very positive and rewarding experience, regardless of the trainee's intentions to provide abortion services. Exposure and training can directly dispel myths and misconceptions, but perhaps more importantly, equip the trainee with accurate information and experience to at the very least counsel and refer his/her patients in the future. Building values clarification work and exercises into training can help a trainee to identify his/her personal biases and his/her comfort zone around abortion and women seeking abortions. Such exercises can also help a trainee to clarify what his/her role will be as a health care provider: to counsel and refer patients, to provide some abortion services, to be an active advocate in his/her community and circles, or to undertake other ways of advocating for access to abortion services.
- *Conduct follow-up interviews with physicians who have been trained in abortion services but are not providing abortions.* These interviews should function as assessments of barriers physicians are facing or are concerned about that prevent them from offering abortion services. Some barriers - - such as rapidly rising malpractice insurance costs

for ob/gyns or potential for harassment - - can probably be anticipated, but there are likely other common denominators among trained, non-providing physicians. Once such assessments are completed, the information gathered should be used to develop specific strategies for minimizing, overcoming or removing such barriers. A recent unpublished follow-up survey of PPNYC's Clinician Training Initiative graduates provides an example of an initial attempt to conduct such follow-up. Indeed, the follow-up surveys made an unforeseen discovery: it was not a concern about stigma, harassment, or violence that was keeping some of the graduates from providing abortion. Instead, the graduates cited institutional concerns. Although they had acquired the technical skills they needed, the graduates were afraid they would not have sufficient volume of cases, were unsure how to access malpractice insurance, and did not know how to integrate abortion provision into their medical practices. While the information the Clinician Training Initiative has gleaned from their follow-up work is unpublished, it has nonetheless provided important feedback on the institutional barriers their graduates faced when they sought to provide abortions, and how participants can be better prepared to confront and deal with these barriers through the Clinician Training Initiative. Efforts to conduct similar evaluations of abortion training programs and then publish and disseminate those results are a necessary next step.

- *Conduct interviews with younger physicians who do provide abortions to determine why they offer this service.* It is well documented and fairly widely understood that many of the graying physicians providing abortion services today are those who experienced and witnessed firsthand the trauma and horrors of illegal abortions; a commitment *not to return* to those days motivates their work. However, physicians who have come of age in the post-*Roe* era have no direct experience of the pre-*Roe* abortion situation, and there is widespread speculation that this explains why younger physicians are reluctant to become abortion providers. Information needs to be gathered on what motivates newer physicians to not only become, but also to remain abortion providers. Such information needs to be disseminated among medical students, residents, and non-abortion-providing physicians, and integrated into the training process/experience.

Beyond these specific suggestions, the importance of publishing and disseminating this type of research and information cannot be overstated. Evidenced-based medicine is considered the standard of care in the delivery of abortion services, but a large hole exists in the published research regarding developing and sustaining evidence-based abortion training programs. While some variance in the specific institutional and community/colleague barriers experienced by those endeavoring to initiate abortion services and/or abortion training is expected, a core set of barriers can almost be anticipated or predicted for many settings. Those clinicians who have already dealt with and overcome such obstacles should be charged with publishing - - or at the very least identifying alternate ways to widely disseminate - - accounts of their experiences, set-backs, accomplishments and strategies for the benefit of those looking to develop new such opportunities. Such contributions will be invaluable to the future of abortion service delivery.

- 4) Promote dialogue among medical professionals at gatherings of all types (i.e. medical school symposia, Grand Rounds, and professional meetings) that will encourage understanding of the rewards and personal gratification of providing abortion services.

Probably more than with most other medical procedures, patients who access abortion services commonly express to those who provide them with this health care, a significant sense of relief and sometimes overwhelming sense of gratitude. This offers a unique opportunity for the provider to share in the patient's positive feelings immediately after the treatment. The personal and anecdotal experiences reported by the Symposium participants confirm that some of the most significant and long-term rewards they reap from abortion work are emotional. As described by abortion providers themselves, every woman seeking their help has her own situation and circumstances. Understanding her story - - and the significant role she/he as the provider is able to play in that story - - is at the heart of each provider's commitment to abortion service. The voices of providers speak clearly:

- "I know every time I do an abortion on a woman who chooses it, I'm saving her life literally, figuratively."
- "The appreciation I receive from patients having an abortion is the reason I continue to provide. These are some of the most heartfelt 'Thank you's' that a woman's health provider will hear."
- "As a physician practicing general ob/gyn for 25 years, I always considered abortion to be an important part of women's health care, and my most appreciative patients through the years were those whom I cared for in their real time of need."

It can be difficult in a training context for the trainee to have an opportunity to truly experience these rewards by connecting with the woman he/she is helping. Trainees may not have the opportunity to follow patients through the process, from the initial intake and counseling through recovery and follow-up. The Symposium participants agreed that such opportunities appear to be essential to the building of long-term commitment to abortion provision. (For more extensive discussion of training opportunities that address experiential rewards of abortion provision, refer to Finding 3.)

A second long-term reward, shared particularly among abortion providers who were treating women in the era before *Roe v. Wade*, was the opportunity to have been "pioneers" in the field. Providers in residency programs, emergency rooms, and in private practice at the time abortion was legalized in the United States could not only provide the first legalized abortions, publicly and openly, but they were able to develop new techniques and set medical standards that would pave the way for future generations of providers.

Today's new providers are training and establishing practices in a socially different era, where opportunities for such pioneering may be limited, or at least less obvious. Yet the opportunities for some physicians to feel they are leaving their mark in a larger medical context remains. Symposium participants suggest several areas to explore for pioneering opportunities:

- Pioneering efforts are needed to normalize and integrate abortion into the comprehensive system of health care delivery. One approach is to find new ways to emphasize the public health aspects of legal abortion and to find ways to disseminate and discuss this information in public and professional circles (refer to Finding 1, Recommendation 2).
- Pioneering efforts are needed to develop successful and sustainable training programs for residents in abortion training. While there is evidence to suggest that the number of residency programs that offer abortion training has increased over the past several years, in many programs, abortion training is difficult to identify, hard to fit into a busy program schedule as an elective, or not available at all. A single model will not fit for incorporating abortion training into all ob/gyn and family practice residencies. It is therefore essential that physicians and faculty seek to develop new training opportunities that will be successful within their existing programs, and seek to treat abortion care as simply one more component of comprehensive women's health care, so that abortion training becomes integrated and sustainable in the long term.

## FINDING II: *REVISING ABORTION TRAINING RESOURCES*

Existing abortion training materials, curricula, and clinical experiences have appropriately emphasized development of technical skills. The Symposium participants find that a re-examination of the assumptions that guided the development of these materials is needed in order to facilitate production of a second generation of training resources that will add features to better motivate trainees to continue providing abortion services, and equip them with the necessary skills and resources for navigating institutional, collegial, and other barriers.

### BACKGROUND:

To facilitate the abortion training initiatives and programs developed following the 1990 Symposium, numerous resources were created, including a state-of-the-art textbook, comprehensive didactic and clinical curricula, and “how-to” guides for establishing training programs. Some resources focus on a single aspect or topic of abortion care; some focus on options counseling or post-abortion care; and some focus solely on the technical clinical skills associated with providing abortion services. Some resources have been specifically designed for use in a particular program, while others are adaptable to various audiences, specialties, or programs. There is no evidence, however, that any of these has more successfully motivated or encouraged trainees to make a long-term commitment to providing abortion services than the others. In fact, none of these curricular resources have explicitly focused on the issue of provider commitment.

One of the earliest abortion training curricula was developed by Vermont Women's Health Center and published in 1973. This was followed in 1995 by the National Abortion Federation's *Clinical Training Curriculum in Abortion Practice* and in 1996 by a customized curriculum *specifically for clinicians from fields other than ob/gyn*, published by the Clinician Training Initiative of Planned Parenthood of New York City. In addition, in 1999 the National Abortion Federation published an abortion-training curriculum specifically for advanced practice nurses and physician assistants:

*Principles of Abortion Care: A Curriculum for Physician Assistants and Advanced Practice Nurses.* The approach taken in each of these efforts varied, and each included unique strengths and weaknesses in terms of their universal applicability.\*

While the development of these and other resources and curricula have proven to be critically important in ensuring that abortion training could be undertaken in a wide variety of settings and for a range of aspiring providers, the Symposium participants agreed that the available resources and prevailing training methods have fallen short of ensuring the necessary long-term commitment to service provision among those clinicians who have been trained. A next step in the development of abortion training materials, curricula, and clinical experiences should explicitly address this issue by identifying ways to tap into the values and motivations of new providers, inspiring them to commit themselves to long-term provision of abortion services.

In the previous section, reference was made to the fact that today's new providers are training and establishing practices in a socially different era, having not been exposed to the horrors and traumas experienced by women (and their families) seeking abortions during the pre-*Roe* years. This is also of particular relevance when discussing the important components and aspects of abortion training today. The lack of abortion content in medical education - - and even on a broader social level - - includes lack of discussion about the impacts of the legalization of abortion in the United States. However, one particular message that does not escape clinicians considering becoming abortion providers is the threat of violence and harassment towards abortion providers. The fact that several abortion providers have been the target of such violence is a sad, yet undeniable truth in the United States. However, there is no evidence to suggest that these events have had any direct impact on the number of physicians involved in the delivery of abortion care. Abortion education and training, therefore, must not only include commitment-building components, but must also address the issue of violence and harassment towards abortion providers in such a way as to accurately acknowledge these occurrences in their appropriate perspective. Trainees should be equipped with the necessary skills, resources, and support networks to address, prepare for, and - - as much as may be possible - - prevent and diffuse potential issues of harassment and violence.

#### RECOMMENDATIONS:

- 1) Develop targeted strategies for training providers of both medical and surgical abortion among trainees in ob/gyn, family practice, pediatric and adolescent medicine, internal medicine, and emergency medicine, as well as advanced practice clinicians, that are both specialty-appropriate, and training-level appropriate.

Traditionally the majority of abortion providers in the U.S. have been drawn from the specialty area of obstetrics and gynecology. While this is reasonable and logical given the practical emphasis on technical/surgical skills among ob/gyns and the specialty's focus of female reproductive health, for some there are insurmountable tensions between obstetrics and abortion. In fact, strong arguments can be made for abortion training outside of ob/gyn

---

\* Several new curricula and training materials have been developed and published since this Symposium, though how they will be used and how they will affect provider commitment or the number of abortion providers remains to be seen.

programs, including, but not limited to family practice, pediatric and adolescent medicine, internal medicine, and emergency medicine physicians, as well as advanced practice nurses and physician assistants.

- Many family practice physicians already provide obstetrical and gynecological health care services to their patients; providing early abortion services is an integral part of this care and is, indeed, well within the scope of family medicine. In addition, a family practice abortion provider offers the option for women to seek abortion care from a provider with whom she may already have established a longer-term relationship and significant trust. For some women, this option will be more appealing than seeking care from a specialty clinic.
- According to the Alan Guttmacher Institute, almost 1 million adolescent women become pregnant each year. Seventy-eight percent (78%) of these adolescent pregnancies are unplanned, and nearly 4 in 10 adolescent pregnancies are ended by abortion (AGI, 1999). Surveys of both the American Academy of Pediatrics membership and the U.S. physician-members of the Society for Adolescent Medicine revealed significant majorities in both groups support abortion as a pregnancy option for adolescents (Fleming, 1993; Miller, 1997). For those pediatric or adolescent medicine physicians choosing not to be providers of abortion services, there remains a clear need to be prepared to diagnose adolescent pregnancy, provide pregnancy options counseling, and make appropriate and trusted referrals for their patients.
- While the practice of emergency medicine differs significantly from ob/gyn, family practice, and pediatric/adolescent medicine in many ways, emergency medicine physicians are nevertheless exposed to women with unwanted pregnancies. First, a notable number of women are diagnosed with pregnancy when they present in the emergency department for other conditions. As the diagnosing physician, these health care providers need to be prepared to provide pregnancy options counseling and make appropriate referrals for care. Second, it is necessary for emergency medicine physicians to be trained to appropriately recognize and manage abortion complications among women who present in the emergency department, including recognizing when a symptom is normal and does not require intervention.
- Doctors of internal medicine focus specifically on adult medicine. As described by the American College of Physicians, among other skills, internists bring to patients “an understanding of ... women’s health...” and effective treatment of common problems of the “... reproductive organs.” In addition, one particular subspecialty of internal medicine is adolescent medicine. As has already been discussed, adolescent women and adult women alike are often faced with unwanted pregnancies. As specialists in the care of adults, providing some degree of abortion services certainly falls within that scope.
- A significant body of research supports not only the competence of advanced practice clinicians in delivering all components of first-trimester abortion services and post-abortion care, but also documents the interest and commitment of advanced practice clinicians in providing abortion services, and support for their colleagues who do or would (in light of current legal restrictions) (Freedman et al, 1986; McKee and Adams, 1994). In addition, advanced practice clinicians have proven to play a critical role in the delivery of health care services to rural and underserved communities.

Providing abortion services has proven to be well within the scope of practice of advanced practice clinicians, and offers the potential to expand the availability and delivery of abortion services to areas that are currently without such services.

However, it cannot be assumed that a strategy, curriculum, or resource designed to motivate abortion training and provision for clinicians in one specialty area will be appropriate for clinicians in another specialty area. On the contrary, specialty-appropriate and training-level appropriate targeted strategies need to be developed to train providers from different medical specialties. In developing these strategies, the Symposium participants emphasized the following considerations:

- Materials should be tailored for all levels of medical experience, including established/practicing clinicians, attending physicians, residents, and medical students.
- Approaches may need to be tailored to the culture of different specialties. In addition to the earlier discussion about the public health context of abortion, approaches should consider the niche within each specialty in which abortion fits.
- Rural health care providers should be targeted specifically and separately for the special role they can play in the health care of women in those rural communities.
- Particular efforts should be made and care should be taken to recruit and train appropriately skilled second trimester abortion providers because of the technical challenges of later procedures.

Additionally, medical abortion and manual vacuum aspiration for early pregnancy termination are important options to consider in efforts to expand access to abortion services through a wider network of clinicians across multiple specialty areas. As long as appropriate systems for referrals and medically indicated surgical intervention are in place, medical abortion and manual vacuum aspiration techniques offer two additional abortion options - - each with its own advantages - - for both providers and women. Both have been proven to be highly effective with minimal complication rates and high levels of patient satisfaction. Both are procedures that can be performed in the privacy and comfort of a clinician's practice and present important options to expand women's access to abortion services.

- 2) Focus curriculum development efforts for both didactic and clinical training experiences on the creation of new, innovative, and adaptable training opportunities that can be tailored to meet the specific needs and experiences of individual trainees.

After the first year of PPNYC's Clinician Training Initiative, it was clear that clinicians coming from fields other than ob/gyn had different training and clinical experiences, and therefore different training and clinical experience needs relative to abortion. In particular, compared with clinicians from ob/gyn programs, clinicians from primary care backgrounds have less surgical training, both in terms of general operative technique as well as instrumentation of the uterus. On the other hand, primary care clinicians have more training



and experience with patient counseling and emotional support. The development of a curriculum specifically for non-ob/gyn clinicians is an initial example of a specialty-appropriate, training-level appropriate training resource.

PPNYC's "Surgical Abortion Education Curriculum" was specifically developed to teach the practice of first trimester abortion using local anesthesia and designed for residents in specialties other than OG/GYN and for physician assistants. This curriculum does not define a standard of care, nor does it suggest that this is the only clinical approach. The curriculum includes five teaching modules; each contains preparatory reading material, interactive, didactic sessions (including cases for discussion) and direct clinical experience. The curriculum encourages participation in the case-based discussion and problem-solving.

The Symposium participants find that a re-evaluation of existing training models, resources and curricula is a necessary next step. Such an evaluation must include assessing what components of each model, resource or curriculum strike personal "chords" with clinicians in such a way as to motivate them to make a commitment to providing abortions, as well as identifying any pieces that may be in conflict with this goal. Concerted efforts - - such as those described in the PPNYC "Surgical Abortion Education Curriculum" example - - must be made through the models, resources and curricula used for training to "connect" with trainees in such a way as to foster a long-term commitment to abortion provision.

In addition to the inclusion of types of "motivational" components in abortion training, the Symposium participants identified the need for training materials that can be adapted for different trainee audiences, time constraints, and situations. Examples include:

- Materials that can be adapted to shorter time-blocks, as well as for use as self-study or self-learning guides, and web-based materials that the trainee can access on her or his own time.
  - An outline or checklist of steps and protocols to guide trainees through procedures.
  - Educational materials for providers to use *with* patients, that patients can then keep as a resource.
  - Web-based materials that are easily (and freely) accessible.
- 3) Ensure that training materials, curricula and experiences move beyond the technical and procedural aspects of abortion to include regulations and legal restrictions adopted by state and federal governments, billing and insurance reimbursement filing procedures, and other administrative issues. In addition, trainees need to be equipped with the skills for confronting and successfully overcoming the very real and practical barriers that can prohibit translating their training into the delivery of services, including institutional barriers, malpractice insurance, resistant attitudes from staff, colleagues, and/or family, and concerns about violence and harassment.

In every abortion training program/situation, some time and energy are spent teaching clinicians elements of the abortion procedure that many will not likely perform, such as pregnancy options counseling. This in no way devalues the counseling component of the abortion "process," yet depending on the model of delivery of abortion services, the clinician

may ultimately cede this responsibility to someone else. Family medicine or other clinicians providing abortion care in the context of a private practice may very well conduct pregnancy options counseling themselves. In a family planning or abortion clinic model, however, dedicated staff generally manage this aspect of care. Nevertheless, exposure to and training in communication skills is not only essential from the perspective of a continuum of care, but it also develops in the clinician an empathy and respect for the patient, and an appreciation for that particular facet of care.

Similarly, a need exists to teach some of the more “practical” and less “procedural” aspects of providing abortion services. As one Symposium participant put it, there is “the business of medicine” that has far less to do with the physician-patient relationship than it does the administrative matters associated with practicing medicine and accommodating the often politically-motivated regulations and requirements associated with abortion provision. Consistent with the findings of PPNYC’s CTI-graduate follow-up survey, “How to use a curette or administer mifepristone is only part of the picture,” one participant noted. “We need to take training to the next level and go beyond the purely medical issues.”

Much emphasis has been placed in recent years on “mainstreaming” abortion, and encouraging privately practicing clinicians to incorporate abortion services into general ob/gyn or family medicine practice. Yet in order to work towards achieving this end, training needs to address directly or provide resources for the following:

- Understanding the public health issues associated with access to abortion.
- Participating in values clarification work around abortion so that trainees are not only aware of their own particular values and beliefs, but are better able to help their patients evaluate their values and beliefs around abortion.
- Engaging in “commitment-building” experiences that reinforce an understanding of the public health issues around abortion, one’s personal values about abortion, and the emotionally rewarding connection providers can establish with patients.
- Educating providers about the legal landscape of abortion in their own states. Common abortion regulations include reporting requirements, targeted regulation of abortion provider laws, also known as TRAP laws (these laws single out abortion clinics for unnecessary and restrictive regulations, including structural, licensing, and other burdensome requirements, or which regulate clinics as hospitals or ambulatory surgical centers), state mandated scripts that must be used for obtaining "informed consent," mandatory waiting periods, parental involvement laws, special regulations for second trimester abortions, and laws governing treatment of fetal tissue.
- How and when to file claims for insurance reimbursement for abortion services, or alternate methods of billing for those in private practice.
- Where and how to purchase necessary materials, supplies and equipment; how to “build out” an office or clinical space to create an appropriate environment.
- What special malpractice risk management should be in place, including information on what kinds of forms will be necessary to develop (such as informed consent), and what particular legal information must be covered in each form.

- Addressing institutional barriers that prevent the implementation of abortion care (ranging from support from peers/colleagues/coworkers to potential increases in administrative tasks).
- Obtaining malpractice insurance.
- Developing and maintaining security systems and protocols.
- Preventing and responding to acts of harassment or violence.
- Conscientiously and effectively advocating among colleagues and communities regarding the need for and the establishment of abortion services and abortion-training.

(For further discussion on training and evaluation issues beyond the technical aspects of abortion care, see Finding 3.)

- 4) Develop specific competency assessment criteria to be used in determining when training of a provider is complete. These should include evaluation by patients and clinic staff, in addition to technical mastery, so that evaluation is based on experience with the wider range of competencies needed to sustain commitment to abortion provision.

Many clinicians and organized training programs involved in conducting abortion training have developed a set of criteria or benchmarks by which they gauge and measure the acquisition, development, and competence of necessary skills. While there is great consensus among abortion providers regarding the importance of abortion training for a new generation of providers, a consensus is lacking in terms of evaluating how much training is enough, and when the training of a provider is complete. Consequently, there is no standardized list of competencies for trainees to master, nor a standardized evaluation tool.

Symposium participants believe, however, that it is possible and necessary to identify competencies and measures of mastery within the context of this limitation. Important components to include in training, competency, and evaluation should be:

- provider training in patient interviewing/counseling/communication to minimize the disconnect between counseling, the technical procedure and follow-up care;
- the pharmacology and protocols for medical abortion with mifepristone/misoprostol and methotrexate/misoprostol;
- manual vacuum aspiration;
- the use of ultrasound as a tool for gestational dating, as well as visualization of the uterus at various stages of pregnancy and post-abortion;
- first trimester surgical abortion instrumentation and techniques; and
- follow-up care.

Taking training to “the next level” also merits discussion of moving training outcomes beyond competency to a higher level of skillfulness, which incorporates not only the technical mastery of a certain skill, or set of skills, but also to the performance of these skills in a clinical setting with a greater level of autonomy, confidence, and efficiency. As this “higher level” is a difficult concept to define precisely, it is beyond reason to suggest that a set of measures could be developed by which to assess it. However, the Symposium participants

recognized the need for those clinicians involved in abortion training to engage in this larger conversation around defining this higher level of skillfulness as it relates to abortion training and the delivery of abortion services. Specific strategies and ideas will need to be developed to move abortion training resources and programs in a direction that facilitates training to this next level, rather than only training-to-competency.

Symposium participants also suggest that evaluation of a trainee not be based solely on technical mastery of the skills associated with the abortion procedure, but also include evaluation by patients and clinic staff regarding communication skills, ethics, conduct, and other facets of care that affect the quality and delivery of care in a clinical setting.

### **FINDING III: *CONNECTING WITH PATIENTS***

Delivery of quality abortion care includes more than exercising a technical medical skill. Abortion service provision is an area of medicine unique in the immediacy and intensity of feelings it evokes on the part of patients. The Symposium participants find that implementation of new ways to keep trainees connected to their patients, and thereby the emotional rewards of doing this work, is critical.

#### **BACKGROUND:**

As discussed earlier, perhaps the most significant and continuously motivating reward for the clinicians who provide abortion services is the emotional return they receive from the relief and gratitude expressed by their patients. Long-time providers among the Symposium participants agreed that it is all too easy to lose touch with the strong sense of having made a positive contribution to patients' lives in service delivery models where clinicians' contact with patients is limited to performing the routine technical procedure while support staff involved in patient care manage the other aspects of interacting with patients. As noted in Carole Joffe's 1995 book, *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade*, once the technical and procedural aspects of abortion provision have been mastered, the procedure can quickly become routine and unchallenging. Removing both the professional challenge as well as the experience of the "whole" woman can nullify the potentially significant emotional rewards of providing abortions.

In order to ensure that providers experience the positive reinforcement that helping patients through a reproductive health crisis entails, a fundamental re-thinking of our training and service delivery models may be needed. Not only must abortion be an expected component of residency training for physicians whose specialties include treating female patients of reproductive age, but part of that education also needs to focus on reinforcing the connection between patients and providers through all the phases of abortion care.

This finding, in fact, is closely associated with the two prior findings: it is very likely that the key to evoking a long-term commitment to providing abortions lies in the personal, emotional rewards to the provider, and it is critical that finding ways to connect trainees to their patients and these emotional rewards be a part of the development of new training materials, curricula and experiences.

## RECOMMENDATIONS:

- 1) Promote among trainees an orientation to “care” by placing increased emphasis on patient-centered models of care, including patient counseling and communication skills in provider training, and maintaining provider continuity in clinical settings (from intake through recovery and follow-up).

The nature of abortion dictates that for some women it is a very difficult and emotional time and process, while for others it is neither difficult nor fraught with emotion. In order to provide the highest level of care to a patient, it is necessary that the provider be in-tune with the patient’s individual needs in this regard. The resident trainee, by virtue of her or his defined role, values technical skill-building processes, and this is particularly true for the specialties of surgery and ob/gyn. However, in order for a provider to be in-tune with a patient’s needs and to experience the positive reinforcement that the patient is likely to express after her abortion, it is necessary to marry this emphasis on technical skills with one that is better oriented towards re-integrating the clinician into closer communication with patient counseling and recovery processes. This is not only good for the clinician, it is good for the patient.

In the past decade in particular, a growing body of research and an increasing number of conversations in professional medical circles have focused on “patient-centered care,” how to define this concept, and what it means in actual practice. A 2001 report from the Institute of Medicine (IOM), “Crossing the Quality Chasm,” addressed in specific terms the need for the training of health care professionals to be patient-centered. “Crossing the Quality Chasm” identified a specific set of values and skills on the part of clinicians that should be included in patient-centered care. Among them - - and of particular relevance to abortion provision - - were respecting patients’ values, preferences and expressed needs, providing emotional support, communicating positive educational health messages, and understanding the patients’ experiences with regard to the treatment outside the treatment setting (IOM, 2001). While care delivery models that rely on other staff to handle all but the technical aspects of abortion services can and have been successful in ensuring that patients’ needs have been met, the advantages of keeping the clinician more directly involved in meeting each of these goals are becoming clear.

A very real potential barrier to teaching patient-centered care is the “hidden curriculum,” whereby organized educational programs and interventions have less impact on trainee behavior than do faculty and resident role modeling. Hafferty and Franks demonstrate that what is learned via this “hidden curriculum” can often be in stark conflict and contradiction with the goals and content of formal courses and educational initiatives (Hafferty and Franks, 1994), in this case, valuing abortion as an acceptable and appropriate pregnancy option for women and practicing a model of patient-centered care.

Other significant barriers to teaching and learning patient-centered care include a lack of continuity in patient care, particularly in hospital situations, that limit a trainee from exposure to the complete course of patient care, as well as a “whole” person view (Glick and Moore, 2001); and the “biomedical model” that prevails in medical education and focuses on

the existence of signs, symptoms, or disease states, their biomedical framework, and their treatment. Such a model takes these indicators out of the context of a patient's daily life and environment, and thereby reduces the patient to his/her signs and symptoms, preventing a perception - - and treatment - - of the "whole" patient (Mead and Bower, 2000).

In 1999, the Kaiser Family Foundation released a report prepared by the Picker Institute, evaluating the quality of abortion care from the patient's perspective. Data from the report indicate that abortion patients report high levels of satisfaction with the care they receive (60% rated their care as "excellent" and 98% rated it as "good" or better), and that almost nine in ten patients reported being treated by staff with "a lot" of dignity and respect. The report further identified specific aspects of abortion care that are most important to women. Those aspects shown to be most closely correlated with women's overall rating of abortion care were satisfaction with information and counseling provided by the clinic; staff attention to preserving the patient's privacy; confidence and trust in staff; and being treated with dignity and respect by staff (Picker Institute, 1999). The findings documented in this report clearly illustrate the importance of "patient-centered" care in the delivery of abortion services.

The opportunity, then, to train new clinicians in abortion in clinic settings offers a unique environment to address some of these concerns and barriers. Abortion training should include exposure to and participation in all aspects of patient care and a clinic setting offers the opportunity to follow a patient through her course of care, beginning with her initial consult or counseling and continuing through her labwork, procedure, recovery and follow-up. In addition, trainees by virtue of the higher patient volume in clinics can gain exposure to a wide variety of patient issues, including a range of potential complications, that might not come to light when seeing only a limited number of cases. This setting also offers the trainee a much greater opportunity to interact with, understand, and treat the "whole" patient throughout the process of her care.

- 2) Ensure that listening and patient-communication skills are not only included in didactic training materials, but are emphasized in training experiences, so that the rewards and benefits that providers typically derive from direct contact in abortion services can be felt in personal and meaningful ways by trainees.

It is widely understood in education that different students excel in different learning modalities. Therefore, it is critical that information is communicated and taught through various methods, including, where possible and appropriate, visual, auditory, kinesthetic, and tactile modalities. This holds true in medical education and abortion training as well. It is essential that knowledge or skills the student is expected to learn, assimilate and apply be communicated and taught through more than one modality, both to reinforce the information as well as appeal to the different types of learners. With specific attention to abortion training, the application of multiple learning modalities is important not only to technical skill development, but equally as important to patient-counseling skill development as well. Not only do trainees need to hear in didactic training and from established clinicians and role models of the personal rewards that result from abortion provision, but they also need the opportunity to experience those rewards - - such as the intense relief and

gratification a patient expresses to her provider - - firsthand in the patient-interview or patient-counseling context.

In abortion training, both didactic and clinical training materials and experiences must focus on communication with the patient. This includes patient interviewing skills, listening skills, and counseling skills. Regardless of the specialty, the Symposium participants agreed that training in patient interviewing needs to begin earlier in medical school, and be consistently reinforced throughout residency and beyond. Patient interactions need to be valued as highly as the technical skills required to provide services to a patient.

As one Symposium participant put it, “the art of the short term relationship” facilitates the building of trust between the patient and provider, and avoids the relegation of the clinician to an “assembly line” experience that can occur when a patient is passed along through the hands of various staff, each handling a different aspect of her care.

- 3) Expose trainees - - medical students, residents, and advanced practice clinicians - - to medical abortion services. Because the provision of medical abortion relies heavily on patient education and preparation, it offers important opportunities for connecting with patients. Further, as medical abortion becomes a service offered by a growing number of providers *over a range of specialty areas*, trainees should be exposed to the skills and systems for delivery of medical abortion services.

Approximately half of women seeking abortion services are eligible for medical abortion by gestational age criteria, and the majority of practitioners can feel comfortable offering it to their regular patients without the need for investment in special aspiration equipment. The availability of medical abortion options using mifepristone or methotrexate presents opportunities for providers who previously did not offer abortion services to now offer abortion within the scope of their practices, as well as distinct advantages that may be appealing to clinicians in private practice, particularly ob/gyns and family medicine practitioners. Without the need for aspiration equipment, medical abortion can be quietly and discreetly incorporated into a practice. Similarly, while medical abortion requires that the practitioner be fully trained regarding protocols, pharmacology, and patient management, the clinician does not need the skills to perform a surgical abortion (so long as a referral is in place for that care to be provided by another practitioner or hospital in the small percentage of cases when it is necessary). Also, many family practice clinicians and ob/gyns have established relationships with their patients over a long period of time. From a woman’s perspective, seeking an abortion from a provider she knows and trusts may be very appealing.

In addition to increasing access to services, primary care settings create another training opportunity for clinicians, and another model of care. Primary care settings are not only a good place to incorporate medical abortion services, but also provide exposure to the emotional rewards of abortion provision for physician trainees, and a venue for advanced practice clinicians such as physician assistants, nurse practitioners, and nurse midwives to become involved with and trained to provide abortion services.

Medical abortion also holds the promise of serving as a frontier for new pioneers in abortion, a need discussed earlier in this report (see Finding 1, Recommendation 4). The development of new models for the delivery of care, ongoing efforts to normalize abortion as part of a full spectrum of health care, and the development of alternative protocols all suggest multiple opportunities for leadership, research, and pioneering work in the delivery of quality abortion care.

#### **FINDING IV: *DEVELOPING STRATEGIES TO SUPPORT ABORTION TRAINEES AND TRAINERS***

Institutional concerns and resistance to providing abortions and abortion training, and especially to presenting this training in contexts outside of the technical skills-building model, remain a significant concern. The Symposium participants find that there is a need for innovative advocacy efforts that will result in more supportive and productive institutional models for abortion training and subsequent abortion service delivery.

#### **BACKGROUND:**

One of the most common sources of resistance to incorporating abortion training into both residency programs and clinics is concern about the potential costs versus benefits of training. The Symposium participants recognize that such concerns, including issues of financial costs, support or resistance from health care staff, and determination of the content of an abortion training rotation and how it would fit into a program and a resident's time are legitimate. However, these need to be considered relative to the potential incentives motivating residency programs to incorporate training.

The development and inclusion of a new rotation or program to an existing residency program requires multifaceted support from a number of sources. In addition to the obvious concerns such as costs/funding, paperwork, and garnering support from key decision makers, residency program concerns include identifying supportive faculty and staff within the program; ensuring sustainability; and sketching out the details and logistics of the training, administration and evaluation of trainees. Additionally, if the program is going to involve training at an off-site clinic, other issues to consider include developing a relationship with a clinic in the community; verifying malpractice insurance and licensure for trainees; and incorporating training into the clinic's normal schedule. Primary concerns within the clinic about incorporating resident training may include its effect on patient comfort levels, patient load and patient flow, clinic staff, and staff morale.

A number of different training models are in place in different programs and clinics, and no one model will fit all programs or clinics. However, those concerns that are common denominators across all programs and clinics must be taken into consideration and fully addressed in the development of innovative new models that will be productive in terms of generating high resident participation numbers, establishing sustainability within both the residency program and clinic, and evoking in residents a long-term commitment to abortion service delivery.

Additionally, the development of new training opportunities - - regardless of model or venue - - can be significantly impacted and facilitated in several ways. The improvement of support systems and networks, initiation of multi-targeted advocacy efforts, and the cultivation of a publicly-held social



consciousness acknowledging the need for and value of safe, accessible abortion services all hold potential for supporting the development of sustainable abortion training programs.

#### RECOMMENDATIONS:

- 1) Provide multifaceted support for institutions and clinics to work through the logistics of establishing an abortion training program, which can themselves serve as barriers to providing abortion services and training. Institutional issues may be different in different specialty areas, but typical concerns include cost and salary issues for clinical training, legal issues, and involvement of nursing and clinical staff.

Without technical assistance available, the logistics involved in establishing a training program can actually serve as barriers to providing abortion services and training. Perhaps the best resources and support systems in place for institutions and clinics developing new abortion provision and training services are those institutions, clinics and providers that have already been through the process themselves. There are several professional organizations within the abortion community that have the potential to serve as a clearinghouse for support contacts and consultants in establishing new training initiatives, including the National Abortion Federation (NAF), Planned Parenthood of New York City (PPNYC), the Consortium of Planned Parenthood Abortion Providers (CAPS), the Access Project, the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning, and Advancing New Standards in Reproductive Health at University of California at San Francisco (ANSIRH at UCSF).

Beginning in 1998, NAF organized biennial Residency Training Workshops, bringing together clinics and residency programs to develop new training programs, do initial work to address barriers, and problem solve. In addition to such efforts, a need exists for resources and support for residency programs and clinics that cannot attend or participate in such workshops. The production of some new resources may be highly beneficial in the development of new programs. These include evaluation tools for clinics and residency programs to assess the strengths and weaknesses of their facilities within the context of incorporating abortion training; how-to guides, such as the 1998 publication by the Abortion Access Project of Massachusetts and the University of Massachusetts Medical Center, "Abortion Training: A Guide to Establishing an Effective Program at Your Facility"; and a cohort of residency program faculty, clinic administrators and medical directors that can serve as "consultants" to programs and clinics engaged in the process of developing new programs. Areas in which clinics and residency programs could use expert advice include legal issues, security concerns, and post-training obstacles, among others.

Further, there is not enough available information detailing the costs of establishing training programs. As discussed under Finding II: Revising Abortion Training Resources, the published literature to date does not include accounts of the experiences, obstacles, and strategies for developing new training programs. This information must not only be available and disseminated among the abortion-providing and -training community, but must also address in real and practical terms the actual costs - - monetary, time, and staff - - of developing and sustaining a successful abortion-training program.

- 2) Identify and overcome barriers for clinicians who want training, including peer supported resistance. Encourage and facilitate the development of advocacy roles specifically for medical students, residents, training faculty, advanced practice clinicians and professional organizations. Encourage and cultivate new potential leaders in abortion service advocacy by bridging the gap for students leaving Medical Students for Choice and initiating their residency program training.

The Symposium participants believe that it is not enough to simply say that abortion training is important; more ideas and efforts are necessary. If new generations of providers are to become involved, it is vital that they understand how and where to get involved, and what they specifically can do. Specific advocacy roles need to be developed for each of the priority training groups, including medical students, residents, training faculty, and professional organizations. Medical Students for Choice (MSFC) is a noteworthy example of an organization that has helped a particular population to organize, assess, and take meaningful action towards increasing abortion training. Individual chapters located at more than one hundred medical schools around the country and now in Canada are assessing the current strengths and weaknesses of their curricula, identifying supportive faculty within the school to help, and developing appropriate and innovative ways to infuse abortion education into their medical school education.

Similar efforts need to be developed to engage other populations as advocates for abortion education, training, and provision. A significant target for such efforts is the cohort of medical students in their third and fourth years that will soon be matriculating into residency programs in various specialties. MSFC's efforts to improve abortion training in medical schools across the country should not be underplayed, however the results and value of these efforts will be felt more by first and second year medical students - - who are still primarily involved in a didactic curriculum - - than by third or fourth year medical students, who spend significantly less time in the classroom and a great deal of time in clerkship rotations. The Symposium participants strongly suggest that bridging the gap between medical school and completion of residency training will encourage and cultivate new potential leaders in abortion services and advocacy. Finding ways to assist third and fourth year medical students in expressing their interest in and demanding training in abortion, not only in medical school and clerkships, but in their residency programs as well, should be a priority.

Residents and training faculty in residency programs also need initial models for advocacy within their programs if they are expected to stand up in the face of institutional and peer-supported resistance to abortion training. Positive models for how to effect change within the system - - without alienating activists or decision-makers - - are critical. Advocacy roles need to be designed with personnel turnover in mind, developing sustainable efforts that can be carried on as residents and training faculty may change.

Professional organizations also have a significant role to play in advocacy. The specific niche an organization can fill will vary depending on the nature of its work, but opportunities for advocacy abound. Accurate information about the safety of abortion, the necessity of choice, and the commitment and competence of providers needs to be widely disseminated, ranging

from the public to state and federal policy makers. Professional organizations - - particularly those that represent abortion providers and supporters - - have the responsibility of calling academically-oriented organizations to task to mandate and ensure the inclusion of abortion training in residency programs. The development, diffusion, and integration of abortion training resources, materials and curricula present other avenues for organizational involvement. Abortion providers need to become actively involved in mainstream medical organizations and mainstream groups to help normalize abortion as a component of comprehensive health care.

- 3) Continue efforts to promote the integration of mandatory abortion training into standard training in ob/gyn, and begin similar initiatives for family practice, pediatric/adolescent, internal and emergency medicine, and advanced practice clinician training programs. Not only will such training directly dispel misinformation, myths and misconceptions associated with abortion provision, but it will also equip providers with accurate information and experience to counsel and refer patients who need abortion care. Moreover, it will also teach the positive and rewarding aspects of providing abortions to women who need them.

As discussed under Finding 2, although abortion in the U.S. has historically been associated with the ob/gyn specialty, there is no reason ob/gyns should be exclusive providers of abortion services. There are a host of reasons for clinicians from other specialties, including those from family practice, pediatric/adolescent medicine, internal and emergency medicine programs, to be trained and able to provide abortions and/or treat women who have had abortions. Efforts to increase the availability of abortion training in ob/gyn programs have proven successful in the past decade, yet there remains much progress to be made in integrating abortion training as a mandatory component of all ob/gyn programs. The Symposium participants recognize that these efforts need to be renewed and continued with new ideas and energy, engaging medical students, residents, faculty, and clinics.

New and innovative initiatives must be undertaken to achieve the inclusion of abortion training in residency programs of other specialties. These efforts must begin at the most basic level, dispelling myths and misconceptions associated with abortion, and clearly illustrating the linkages between the particular specialty - - such as pediatric/adolescent medicine - - and the need for abortion training. As mentioned earlier, exposure to and training in abortion serves not only to teach technical skills, but also to sensitize providers to the abortion experience, understand the process a woman undergoes - - both in terms of her emotional journey and counseling, and the technical procedure itself - - and enable them to counsel and refer patients, even if they choose not to become abortion providers.

- 4) Continue coalition-building work on behalf of advanced practice clinicians. A priority should be advocating for interpretation of or changes to existing laws to expand the role nurse practitioners, physician assistants, and nurse-midwives can play in the delivery of abortion services.

The last decade has seen a number of prominent professional organizations adopt and put forward statements and resolutions in support of increasing the role of qualified nurse practitioners, physician assistants, and nurse-midwives in delivering abortion care. Among

those are the American Public Health Association (APHA), the American Medical Women's Association (AMWA), Physicians for Reproductive Choice and Health (PRCH), the American College of Obstetricians and Gynecologists (ACOG), and the National Association of Nurse Practitioners in Women's Health (NANPWH, formerly known as NANPRH).

These statements and resolutions are founded in a significant and growing body of research which illustrates the competency of advanced practice clinicians (APCs) in delivering first trimester abortion services as safely and effectively as physicians (Freedman et al, 1986; APHA, 1999). Support for expanding the scope of practice for advanced practice clinicians also comes from within their own ranks. Significant numbers of advanced practice clinicians believe that they and their colleagues are capable of providing abortion services. These clinicians are willing to support colleagues providing abortion services, and many are interested themselves in providing abortion services (McKee and Adams, 1994). The growth in membership of organizations such as Clinicians for Choice, and the development of new programs and projects to support expansion of APC roles, such as New England Midlevel Training Consortium (NEMTC) and the New Abortion Provider Training Initiative (NAPTI) of the Abortion Access Project provide additional examples of support for the role of advanced practice clinicians in abortion care.

Professional associations representing advanced practice clinicians, and other supporting organizations - - including Clinicians for Choice, the Abortion Access Project, and others - - have already developed appropriate training resources and curricula, and work to organize, educate and advocate for the inclusion of abortion services in the scope of work of APCs. However, significant legal barriers and restrictions remain. Legislation that specifies who may and may not provide abortions in each state severely restricts the ability of qualified APCs to provide abortion services. As of the writing of this report, 44 states in the U.S. have laws on the books that specify abortions may only be provided by physicians. In some states scope-of-practice provisions may allow non-physician clinicians to perform abortions, however it is not clear in all cases whether these newer provisions (sometimes in the form of new legislation) supercede the enforcement of older laws, resulting in a highly diverse and unclear legal landscape for many APCs interested in performing abortions. State legislation, attorney general opinions, or other administrative rulings have clarified the situation in some cases. For instance, in states that technically still have physician-only laws on the books,

- the Connecticut Attorney General concluded that this restriction applies only to surgical abortion services;
- California legislation signed into law in late 2002 specifically allows for the provision of medical abortion by licensed medical professionals in addition to physicians (e.g. advanced practice clinicians);
- a court permanently enjoined the Montana law from being enforced; and
- the Washington State Attorney General affirmed the authority of nurse practitioners to provide medical abortion.

In addition to efforts and initiatives already established and underway, the Symposium participants recognize that coalition-building work and advocacy for changing or

reinterpreting these restrictive laws must continue and grow in a concerted effort to expand the scope of practice of nurse practitioners, physician assistants, and nurse-midwives to include abortion services. Such efforts would thereby increase the pool of potential abortion providers in the United States and women's access to those providers.

- 5) Explore and develop new models of abortion provision. To facilitate this process, assemble teams of abortion-provider consultants with expertise ranging from legal issues to security concerns to post-training practical and institutional obstacles to serve as resources, answer questions, and provide workshops for new providers and/or clinics.

The exploration of “partnering” models, whereby providers of medical abortion work with surgical abortion providers to provide suction completion for failed or incomplete medical abortions, or to treat women presenting too late for a medical abortion might prove fruitful. Depending on the community, the back-up provider could be an individual physician, a small group of providers, or a hospital institution. Issues to be considered might include developing relationships with surgical providers willing to assume the legal responsibility for treatment of complications of other clinicians' treatments (given the realities of malpractice insurance today), and establishing confidence of both partners that the initial care provider is able to recognize when a referral for intervention is needed.

As clinicians from many specialty areas begin training in and providing abortion services, new and different models of care are likely to emerge. These models should be shaped not only by the advent of new procedures and new providers, but also by special needs, such as access in rural communities, and the services women want. The development of new and better models of care is an essential component of increasing access to abortion services.

In addition, similar to the discussion of consultants and resources for establishing new training initiatives, a need exists for a cohort of abortion-provider consultants to be available for physicians, clinics and hospitals engaged in initiating abortion service delivery. These consultants should be well-seasoned in navigating barriers, identifying resources, and establishing processes and protocols for delivery of abortion services. They should also be able to provide support on issues ranging from administrative details to patient management, from legal issues to security concerns, and from institutional or colleague resistance to malpractice insurance.

- 6) Continue essential efforts to educate the public about the competence and commitment of abortion providers.

Abortion remains one of the safest procedures available in the United States. Of women who have surgical abortions during the first three months of pregnancy, 97% report no complications, 2.5% report minor complications that can be handled at the facility where the abortion is performed, and less than 0.5% require some additional surgical procedure or hospitalization (Tietze and Henshaw, 1996). Despite these facts, anti-abortion groups and activists have saturated public information with claims that abortion causes fertility problems, ectopic pregnancies, breast cancer, “post-abortion syndrome,” and myriad other health

complications. *A significant body of medical research has refuted these claims*, yet the general public still believes many of these myths and misconceptions. It is therefore essential that efforts to *accurately* educate the public about the competence and commitment of abortion providers not only continue, but are carried out in meaningful ways that effectively combat the host of misinformation that is so readily accessible to the public.

In addition to assuring the public about the competence and commitment of abortion providers, abortion needs to be discussed in the context of its public health impact. The cases of women who received illegal, unsafe and unsanitary abortions and flooded emergency rooms in the era before *Roe v. Wade* have faded into the memories of the physicians who cared for these women and those whose families and loved ones were directly impacted, and seem more or less forgotten by the general public. In order to prevent these days from returning, open discussions must take place about the significance of safe, legal, and accessible abortion. The Symposium participants suggest turning to other health issues and learning how they have been assimilated into the social conscience of the public as *public health issues*. In particular, the Symposium participants identified as models and examples the introduction and normalization of immunizations, the reduction in and restriction of tobacco use, and the recognition and condemnation of domestic violence.

## CONCLUSION

Since the first Symposium convened in 1990 to address the growing shortage of abortion providers, significant accomplishments have been made and programs put in place to increase the availability and access of abortion training. The results of these initiatives, however, have not been enough to counter the steady decline in the number of abortion providers. The findings and recommendations outlined by the participants of this Symposium call for a reframing of existing training models and resources in order to evoke a personal commitment from trainees to actively participate in the important and gratifying work of abortion provision. In addition, the findings and recommendations point to the importance of developing among medical professionals, medical educators, and the general public a broad acknowledgment of and support for the quality training that ensures continued safe and accessible abortion services for women.



## REFERENCES CITED

- Alan Guttmacher Institute. Facts In Brief: Teen Sex and Pregnancy. 1999.
- Almeling R, Tews L, Dudley S. Abortion training in U.S. obstetrics and gynecology residency programs, 1998. *Fam Plann Perspect* 2000;32:268-71, 320.
- American College of Obstetricians and Gynecologists, Statement of the Executive Board, January 1994.
- APHA Policy Statement 9917: Advocating for Nurse Practitioners, Nurse-Midwives, and Physician Assistants as Abortion Providers. APHA Public Policy Statements, 1948-present, cumulative. Washington, DC: American Public Health Association.
- Association of Professors of Gynecology and Obstetrics. *Medical Student Educational Objectives, Seventh Edition*. Crofton, MD: APGO. 1997.
- Cartoof VG, Klerman LV. Parental consent for abortion: impact of the Massachusetts law. *Am J Public Health* 1986;76:397-400.
- Federal Interagency Forum on Child and Family Statistics. *America's Children: Key National Indicators of Well-Being, 2000*. Federal Interagency Forum on Child and Family Statistics, Washington, DC: U.S. Government Printing Office. 2000.
- Finer LB, Henshaw SK. Abortion incidence and services in the United States in 2000. *Perspect Sex Reprod Health* 2003;35:6-15.
- Fleming GV, O'Connor KG. Adolescent abortion: view of the membership of the American Academy of Pediatrics. *Pediatrics* 1993;91:561-65.
- Freedman MA, Jillison DA, Coffin RR, Norvick LF. Comparison of complication rates in first trimester abortions performed by physician assistants and physicians. *Am J Public Health* 1986;76:550-54.
- Glick TH, Moore GT. Time to learn: the outlook for renewal of patient-centred education in the digital age. *Medical Education* 2001;35:505-9.
- Gold RB. *Abortion and Women's Health: A Turning Point for America?* New York, NY: The Alan Guttmacher Institute. 1990.
- Hafferty FW, Franks R. The hidden curriculum, ethics teaching, and the structure of medical education. *Acad Med* 1994;69:861-71.
- Henshaw SK. Factors hindering access to abortion services. *Fam Plann Perspect* 1995;27:54-9, 87.



Henshaw SK. Abortion incidence and services in the United States, 1995-1996. *Fam Plann Perspect* 1998;30:263-70, 287.

Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*. Washington, DC: National Academy Press. 2001.

Joffe C. *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade*. Boston, MA: Beacon Press. 1995.

Lichter DT, McLaughlin DK, Ribar DC. State abortion policy, geographic access to abortion providers and changing family formation. *Fam Plann Perspect* 1998;30:281-87.

MacKay HT, MacKay AP. Abortion training in obstetrics and gynecology residency programs in the United States, 1991-1992. *Fam Plann Perspect* 1995;27:112-15.

McKee K, Adams E. Nurse-midwives' attitudes toward abortion performance and related procedures. *J Nurse Midwifery* 1994;39:300-11.

Mead N., Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. *Soc Sci Med* 2000;51:1087-110.

Miller NH, Miller DJ, Pinkston Koenigs LM. Attitudes of the physician membership of the Society for Adolescent Medicine toward medical abortions for adolescents. *Pediatrics* 1997;101:e4.

National Abortion Federation. *Who Will Provide Abortions? Ensuring the Availability of Qualified Practitioners*. Washington, DC: National Abortion Federation. 1991.

National Abortion Federation. Fact Sheet: Safety of Abortion. 1996.

National Abortion Federation. *The Role of Physician Assistants, Nurse Practitioners, and Nurse-Midwives in Providing Abortion: Strategies for Expanding Abortion Access*. Washington, DC: National Abortion Federation. 1997.

Picker Institute. *From the Patient's Perspective: Quality of Abortion Care*. Menlo Park, CA: Kaiser Family Foundation. 1999.

Planned Parenthood of New York City. Unpublished data from follow-up surveys of Clinician Training Initiative graduates.

Shelton JD, Brann EA, Schulz, KF. Abortion utilization: does travel distance matter? *Fam Plann Perspect* 1976;8:260-2.

Tietze C, Henshaw SK. *Induced abortion: A worldwide review, 1986*. Third edition. New York, NY: Alan Guttmacher Institute. 1996.

Trussell J, Menken J, Lindheim B, Vaughan B. The impact of restricting Medicaid financing for abortion. *Fam Plann Perspect* 1980;12:120-3, 127-30.

Westhoff C. Abortion training in residency programs. *J Am Med Womens Assoc* 1994;49:150-2.

Yates S, Pliner AJ. Judging maturity in the courts: the Massachusetts consent statute. *Am J Public Health* 1988;78:646-9.