# PROVIDING EARLY OPTIONS

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**A Publication of The National Abortion Federation's Medical Abortion Education Initiative**

## *How Can We Provide Abortion Services to Diverse Populations: Focus on Language and Culture*

*By Purvi Shah with contributions from Marcy Bloom, Aradia Women's Health Center; Carla Eckhardt, Planned Parenthood Golden Gate; and Lorie Spears, Planned Parenthood Chicago Area*

Today, the United States reflects the largest diversity of race, ethnicity and culture in its history. We recognize that ethnic and racial minorities may face a number of barriers to accessing abortion services, including: difficulty finding an abortion provider, transportation, lack of funds, mistrust of or unfamiliarity with the health care system and medical personnel, and limited knowledge about reproductive health. In some cultures, women are not permitted or are discouraged from learning or asking questions about their reproductive system. Health care providers need to be aware of the cultural and language barriers that women of different ethnicity or race face when seeking reproductive health services.

What is culture and how does it impact abortion care? The terms "culture" and "cultural competency" have become "buzz" words. However, understanding "culture" and "cultural competency" as not just "politically correct" terms but as complicated concepts helps us better understand a person's values, perceptions, and attitudes around their pregnancy. In addition, it helps clinicians and health care providers avoid stereotypes and biases that can impede their efforts in providing high quality abortion care. In this article, we will attempt to demystify these terms and explore strategies to apply the concepts and principles behind them in hopes that it will enable you to better serve your clients.

There are many definitions of culture. Simply defined by the Department of Health and Human Services (DHHS), culture is "a common heritage or set of beliefs, norms, and values". Cultural identity may also extend to members of a particular group not defined by ethnicity or race. For example, gang members, a college fraternity, and even clinicians have their own culture.

The culture of a particular ethnic group influences many aspects of their abortion care needs. It impacts how they communicate their symptoms, which symptoms they report (for example, Asian patients are more likely to report somatic symptoms, such as dizziness, and not their emotional symptoms—Lin & Cheung, 1999), the meanings and beliefs they attach to their pregnancy and their pregnancy options, how they cope with their problems and the social support they have (for example, treatment decisions for Chinese patients are often made by family members rather than the patient—University of Michigan Health System), where they go to seek an abortion, or whether they seek abortion services at all (religious practices and beliefs prevent some women from seeing abortion as an option). A survey of California Latina women revealed that their spouse or partner is the primary influence for Latinas' views on birth control (Planned Parenthood San Diego and Riverside Counties), so we might see that Latinas' spouses and partners have a particular influence in her decisions around abortion as well. In addition, cultural and religious values may impact a woman's ability to practice birth control and subsequently her arrival to your clinic for options counseling. Culture can also influence whether a woman prefers a medical or a surgical abortion. Possible prolonged bleeding and spotting associated with medical abortion may deter Native American women from seeking that option since it would prevent them from participating in traditional practices and ceremonies.

In providing abortion care, cultural norms and beliefs about sexuality, reproduction, gender and gender roles, health care and other sensitive issues all intersect, amplifying the need for culturally competent health care. Therefore, in order to provide effective abortion care, eliminating or at least addressing cultural barriers is critical. The overall goal of building a culturally competent organization is to build understanding, gain trust, increase efficiency of treatment, and produce better treatment outcomes.

In addition to understanding cultural barriers, it is important to address strategies to eliminate language barriers, so as to ensure that patients are receiving high-quality abortion care. For some women, language is a significant obstacle to overcome when seeking abortion care in the US. Language impacts a patient's ability to convey symptoms accurately, understand what is happening to them, and understand the treatment plan and/or

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### INSIDE THIS ISSUE

# Ask An Expert!

*Here are the perspectives of two experienced health care professionals on a common question about medical abortion. Keep in mind, there are many different approaches to setting up medical abortion protocols and managing medical abortion patients, depending on your practice size and setting, your staffing, your clientele, your experience-level, and many other factors. We welcome your suggestions for an "Ask An Expert" question for our next issue.**


*Michelle Fox, MD, MPH* is the Co-Director of Family Planning in the Dept. of Obstetrics, Gynecology, and Reproductive Sciences at the University of Maryland School of Medicine. She has been involved in several medical abortion studies.

*Eric Schaff, MD* is the director of the Family Planning and Reproductive Health Program at University of Rochester and NAF's Board Chair. He was principal investigator of the Abortion Rights Mobilization (ARM) mifepristone trials and has published numerous studies on medical abortion.


**"What is the correlation between thickness of the endometrial stripe on a post-medical abortion ultrasound and the incidence of delayed bleeding 2-4 weeks after a medical abortion?"**

*Michelle Fox, MD, MPH*--Unfortunately the cause of delayed bleeding 2-4 weeks after medical abortion is unknown and there are no reliable signs to predict which patients will have this problem. One study suggests that women with a thicker endometrial stripe at follow-up may have longer bleeding after medical abortion (Harwood et al. *Contraception* 2001; 63: 255-6); however no studies have looked at the relationship between endometrial thickness and delayed bleeding. Two studies demonstrate that endometrial thickness varies greatly after medical abortion and show that once the gestational sac is evacuated, ultrasound does not reliably predict the need for surgical intervention (Harwood et al. *Contraception* 2001; 63: 255-6; Cowett et al. NAF Annual Meeting 2003).

It's important to emphasize that patients presenting with delayed or heavy bleeding after medical abortion should be managed based on their clinical presentation and not solely on the appearance of the ultrasound. In my clinical experience, there seems to be no correlation between endometrial thickness after medical abortion and the risk of delayed bleeding. Delayed bleeding may occur in patients with a normal, thin endometrium at follow-up. Hopefully, future research will shed light on this issue so that we can better predict when this problem will occur.

*Eric Schaff, MD*--I have read Michelle's comments and she has answered the question better than I could.

* Neither the National Abortion Federation, its officers, employees, or members are responsible for ad-

## *Update on Patient Death in California*

Holly Patterson, a woman who was seen on September 10th for a medical abortion at Planned Parenthood Golden Gate, died on September 17th at a San Francisco Bay Area hospital. NAF extends our deepest sympathy to the Patterson family and Holly's loved ones.

In association with the reporting of this tragic event, numerous media accounts have included inaccurate information on the safety of medical abortion and have incorrectly attributed three deaths to the mifepristone/misoprostol regimen. The FDA has not established a causal relationship between mifepristone and the outcome of two of these cases, and has not commented if there is a causal relationship in the Patterson case. One death was the result of a ruptured ectopic pregnancy. An ectopic pregnancy occurs naturally in approximately 2% of pregnancies; left untreated, it may result in death. The second case was a rare clostridium infection and occurred during a clinical trial in Canada. The cause of death in the most recent case was reported as septic shock resulting from a drug-induced abortion.

Mifepristone/misoprostol has a fifteen-year history as a safe and effective method for early abortion and underwent the rigorous FDA approval process for safety and efficacy, which is the pharmaceutical industry's "gold standard." More than 200,000 women in the US have used mifepristone/misoprostol safely since its approval by the FDA in September 2000. In addition, millions of women worldwide have used mifepristone/misoprostol safely since it was approved in France in 1988.


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NAF is the professional association of abortion providers in the US and Canada. We serve those who make choice a reality: physicians, nurses, counselors, administrators, advanced practice clinicians and other health care professionals at medical facilities and offices in 48 states, the District of Columbia, Puerto Rico and 8 Canadian provinces. NAF is unique among reproductive health care organizations in that our mission is focused specifically on keeping abortion safe, legal and accessible.

*The National Abortion Federation (NAF) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to*

# Mifepristone Use in First 18 Months

The safety and efficacy of mifepristone/misoprostol regimens for abortion have been well-documented in clinical trials and in more than a decade of widespread use in numerous countries throughout the world. A study published in the June 2003 issue of *Contraception* (R. Hausknecht. Mifepristone and misoprostol for early medical abortion: 18 months experience in the United States. *Contraception* 2003; 67: 463-465) confirms the safety profile of this medical abortion regimen in general clinical use in the U.S.

The paper outlines the 139 adverse events reported to Danco Laboratories, and subsequently to the FDA, during the first eighteen months of use in the U.S. after FDA approval. From November 2000 through May 31, 2002 the author estimates that approximately 80,000 abortions using mifepristone/misoprostol occurred, which corresponds to an adverse event rate of 0.17%. This estimate of the total number of mifepristone/misoprostol abortions is based on sales data for mifepristone and conservative estimates about the percentage of providers using protocols of 200 mg mifepristone vs. 600 mg mifepristone.

In terms of the specific adverse events reported, five ectopic pregnancies occurred (0.006% 95% confidence interval 0.002-0.15%), one of which was fatal. Thirteen patients required transfusions because of heavy bleeding, including two of the women with an ectopic pregnancy (0.016% 95% CI 0.009-0.028%). All but one of the transfusions in women with intrauterine pregnancies occurred 7-20 days after taking misoprostol. Danco received reports of 117 patients who had a suction curettage, 50 of which were for treatment of heavy bleeding. Nearly all were non-emergent. Ten patients (0.013% 95% CI 0.006-0.023%) received antibiotics for presumed infection. Six patients had allergic reactions to the mifepristone (0.008% 95% CI 0.003-0.016%) that resolved promptly with oral diphenhydramine hydrochloride. One patient with a strong family history of heart disease experienced a non-fatal coronary artery occlusion 5 days after using misoprostol, which she had administered vaginally.

Fifty women (0.063% 95% CI 0.46-0.082%) had an ongoing pregnancy after the medical abortion regimen, all but two of which were subsequently terminated with suction curettage.

Although the adverse event rates in the report may be impacted by under-reporting of these events and an inexact estimation of the total number of medical abortions, the report nonetheless does provide a nationwide assessment of the outcomes of medical abortion with mifepristone/misoprostol in general clinical use. Further, the author indicates that the adverse event rates in Planned Parenthood affiliates, for which the precise number of total patients is known, are comparable to the rates included in this report.

## Does your clinic need medical abortion technical assistance and training?

NAF's Medical Abortion Technical Assistance Program has provided training and assistance to dozens of NAF member clinics across the country. NAF members interested in initiating or improving their medical abortion services have taken advantage of this specialized training by bringing NAF faculty to their clinics for half- or full-day in-services. We have also arranged for technical assistance over the phone.

*Possible areas for assistance:*

- Developing/refining protocols
- Patient volume and/or patient flow
- Medical abortion pricing/drug costs
- After hours triaging
- Legal/regulatory issues
- Ultrasound training
- Phone counseling/intake
- Managing side effects/complications
- Staff values clarification

*If you have a training need, you can contact NAF's Medical Abortion Education Director at (919)967-1673.*

## Reporting Mifeprex™ Adverse Events

The product labeling and the Prescriber's Agreement for Mifeprex™ both specify that providers must report adverse events associated with the use of Mifeprex™ to Danco Laboratories. Accurate reporting of adverse events will enable continued documentation of the safety and efficacy profile of Mifeprex™ in clinical use. Here are some tips about reporting adverse events.

***What to Report:***

- Hospitalizations
- Transfusions
- Surgical interventions for any reason
- Any ongoing pregnancy not terminated surgically
- Miscellaneous: infections, major psychiatric events, allergic reactions
- Other serious and unusual events

***Information Requested:***

- Patient identifier
- Age
- Mifeprex™ lot number
- Duration of gestation
- Clinical summary including dates, dosage, routes of administration of Mifeprex and misoprostol
- Laboratory data including pathology reports if available
- If hospitalization occurred, which hospital was accessed and what was done
- Name of contact person

***Where to Send Information:***

Richard Hausknecht, MD, Medical Director, Danco Laboratories, PO Box 4816, NY, NY 10185 ~ rhausknecht@earlyoptionpill.com, Fax: 212-424-1952

# Providing Abortion Services to Diverse Communities (*Continued from front cover)*

*(Continued from front cover)* suggestions the provider gives, as well as how to adhere to the treatment plan. Poor communication between the patient and provider can be frustrating for the patient as well as the provider and can result in an unsatisfactory outcome.

Patient education and counseling are especially critical components of providing medical abortion services successfully. For instance, it is vital that patients understand how and when to take their misoprostol, what to expect in terms of bleeding and cramping, what side effects are normal and what symptoms warrant a call to the provider. Additionally, some providers of medical abortion struggle with whether they could effectively communicate with and accurately assess the condition of a patient who called with concerns about bleeding or other symptoms during the course of a medical abortion. For these reasons, overcoming language barriers is particularly important in the context of ensuring access to medical abortion services.

*These are 32.5 million foreign-born residents in the U.S. (i.e. those who have migrated to the U.S. and who are not U.S. citizens at birth) representing 11.5% of U.S. population.*
Of these:
~ 52.2 % are from Latin America (including Caribbean, Central America, & South America)
~ 25.5% are from Asia
~ 14% are from Europe
~ 8.3% are from Other Regions

*U.S. Census, March 2002*

The long-term benefits of providing language access to patients "include better communication between patients with limited English proficiency and English-speaking providers, greater patient satisfaction, more confidentiality and truer 'informed consent' in medical procedures, fewer misdiagnoses and medical errors, cost savings through fewer emergency room visits, less staff time needed to communicate and work with non-English speaking patients, and fewer eligibility and payment errors." (National Conference of State Legislators)

***Americans—Who are we?***

- Whites 196.2 million
- Hispanics 37 million
- Blacks 36.2 million
- Asian 11 million
- America Indian/ Alaska Natives 2.7 million
- Native Hawaiians/ Pacific Islanders 0.5 million

*(source U.S. Census Bureau, January, 2003)*

Culturally competent organizations providing abortion services should incorporate the following:

◊ ***A bicultural/multicultural staff.*** Hiring practices should involve and assess ethnic and cultural needs of the organization. Frontline staff, counselors, nurses, and physicians should look like the population they serve so that women from diverse backgrounds feel a familiarity and trust. Periodic evaluations of staff should be administered to ensure that staff is culturally competent and able to appropriately manage situations when patients of different cultures come in for treatment.

◊ ***An action plan*** in place that staff can follow when presented with a culturally diverse patient seeking an abortion. The action plan should address which staff member to call, where to send the patient, and a list of phone numbers for translation services or community organizations that could be of assistance.

◊ ***Training programs*** for staff that:

- Include culturally informed training curriculum—focusing on the impact of culture, race, and ethnicity.
- Address staff cultural bias—this means any preconceived notions or stereotypes staff holds about a particular race, ethnicity, or culture. Staff must be able to address these biases and convey understanding and respect for patients' culture and experiences. Staff must be flexible in patterns of thinking and have the ability, internally, to change false beliefs and assumptions.
- Include training in cultural sensitivity and in specific cultural patterns, especially if a dominant minority receives services from your organization. For example, if the majority of women seeking abortion care in your area are immigrant Russian women, staff should be fully competent in Russian views on sexuality, abortion and family planning, preferred birth control methods, and cultural practices.
- Include staff in brainstorming and designing of the action plan that they will use when a culturally diverse patient comes in for abortion services.

***English Proficiency***

Number of people whose English proficiency rated as "less than very well" in 2000: *19.5 million*

***Language Line***

AT&T language line serves over 142 languages and is available 24 hours a day. Toll-free number is 1-800-752-6096.

◊ ***Relationships within the community.*** Create and build relationships with organizations in the community. Network with other organizations in your community that primarily serve immigrant and refugee populations or work with specific minority groups.

◊ ***A system for engaging family members when appropriate.*** Counselors should always speak with patients privately first, and then bring in relatives per patient request. Counselors should assure the woman that their conversation is completely confidential and the counselor can give as much or as little information to the relative as the patient desires.

◊ ***Attention to legal and safety concerns.*** Many women from other countries associate medical care with government facilities so be clear that this is not true of your organization. Assure her that your services are of the highest quality and that abortion and contraception are legal in the States. Let her know that her legal status is irrelevant to her care and that the INS (Immigration and Naturalization Services) is NEVER involved.

◊ ***A system to monitor your progress.*** Track and record as many experiences with culturally diverse

*(Continue on next page)*

## *SPAN: One Comprehensive Model for Increasing Access and Enhancing Services for Latinas.*

*By Lorie Spears, Director of Abortion Services, Planned Parenthood/Chicago Area*

The front line staff at Planned Parenthood Chicago Area (PPCA) identified the need, based on changing demographics and patient demand, to better serve Latina women. We formed "SPAN", a Spanish work group, to make recommendations and implement plans to increase access and enhance services for these women. Here is a summary of our recommendations.

***Build infrastructure before outreach and marketing*** This includes hiring sufficient Spanish speaking staff

***Answer the phone in Spanish -- Telephone access is key*** Have Spanish speaking staff answering phones; include recorded messages and voice box options in Spanish; teach non-Spanish speaking staff a few phrases (have a cheat sheet by phones) to triage calls; ensure availability of 24 hour emergency on call in Spanish.

***Offer Spanish language classes for staff*** Use Community College or Adult Education; teach in-house using the skills of one of the staff and *Spanish for Healthcare Professionals*. If in-house capacity is limited, use AT&T Language Line for interpreters.

***Provide adequate written materials in Spanish*** This includes not only forms, brochures, fact sheets, consents, but also the signs in the health center, resource materials and referral lists.

***Network, outreach and market*** Partner with Latina organizations; include "se hablo espanol" in yellow page ads; place ads in Spanish language yellow pages, magazines and papers; have an open house; offer educational presentations to other Latina organizations.

***Increase visibility in Latina communities*** Do media on reproductive health for Spanish TV, newspapers, radio (media=free advertising); attend events and hand out referral information at street fairs, film festivals, music and dance events.

## *Providing Abortions to Diverse Communities*

*(Continued from previous page)*

patients as possible. This could be used in subsequent trainings as well as for personnel evaluation purposes. However, so as not to create any additional cultural biases, the experience with a particular patient should not be generalized. Understand that each person comes to you with a unique set of experiences, socioeconomic status, acculturation, etc. For example, views on abortion can be different within a racial/ethnic group. In a survey by the General Social Survey (GSS) group, Puerto Rican women reported higher levels of support for abortion than did Mexican women, even though both are often referred to (grouped together) as Latinas.

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### *Resources on Understanding Patients of Diverse Cultural and Linguistic Backgrounds*

*Islamic Medical Association of North America*
www.islam-usa.com/e40.html
Developed by Muslim physicians, offers information to health care providers on relating to Muslim patients.

*Native American Healing: Special Sites and Links*
www.healing-arts.org/nativelinks.htm
Contains links to other sites related to Native American Indians or their healing ways.

*Hmob Kev Mob Nkeeg- Hmong Health Website*
www.hmonghealth.org
Provides bilingual (Hmong/English) health information resources.

*Center for Hispanic Studies in Nursing and Health*
www.uta.edu/nursing/hispanic
Dedicated to fostering understanding between health care professionals and people of Hispanic origin.

*Afghan Network*
www.afghan-network.net
Includes many resources on the different tribes of people in Afghanistan as well as their languages.

*Taboos in My Culture/Non-verbal Communication*
www.hut.fi/Units/LangSpeech/Ruth/Autumn96/automatic/taboos
This news group on taboos, contains a string of 95 emails as of December 13, 2000, primarily focusing on taboos in Asian countries.

*University of Michigan Health System*
http://www.med.umich.edu/multicultural/ccp/general.htm
Resource on generalizations and facts on African-American, Chinese, Muslim, Japanese, Mexican-American, and Russian patients that may help clinicians better interact with their patients.

# Addressing Language Barriers Do's and Don'ts

*Below are some DO's and DON'Ts to address language barriers and thereby increase the quality of care a patient receives during their abortion procedure.*

***DO:***

- Identify and document the language needs of provider and client population.
- Have advertising, media, and print accurately reflect the services your organization offers in various languages; there are anti-abortion agendas that specifically mislead recent immigrants about their reproductive rights in the United States. Of particular concern, "Crisis Pregnancy Centers" (CPC's) erroneously advertise their services as abortion counseling and offer free pregnancy tests as incentives to visit the centers. Many distribute Spanish-language materials. Women who are unfamiliar with the process of obtaining an abortion in the United States are particularly vulnerable to such misinformation strategies" (NAF National Consortium report)
- Provide translation options:
  - ~ Written materials-pamphlets, brochures, booklet, books
  - ~ Interpreter-Interpretation is facilitating oral communication between individuals who do not speak the same language and may not share the same culture (as compared to translation which is written). Have trained staff and volunteer interpreters available on telephone and in person. When working with interpreters, make sure that you are speaking to the patient and not the interpreter. Make sure you use less complex terminology so that the patient understands and the interpreter is able to accurately translate.
  - ~ Audiovisual resources
  - ~ Drawings
  - ~ Language line-AT&T has a language line that serves over 142 languages and is available 24 hours. The toll-free number is 1-800-752-6096.
  - ~ Bilingual staff
- Monitor the quality of language services.
- Understand that language and understanding are two different things. We have internal biases to check when we are interpreters and providers. For instance not offering medical abortion to non-English speaking patients is about our bias, not the patient's inability to understand.
- Have a safe and welcoming "look" and ambience for non-English speaking woman. Have health pamphlets, magazines, newspapers, etc. in as many languages as you need so that the woman does not feel isolated due to her non-English speaking abilities. Make sure that your art, posters, internal and external advertising, etc. are culturally sensitive for non-English speaking women—they have the same fears as any other woman, and perhaps more, as they may be from a country where abortion is illegal.
- Speak more slowly, not more loudly.
- Be creative. If you do not have interpreters, use the AT&T language line and have cordless phones with hands free capability available to provide privacy in the exam room.
- Use cultural mediators from community partners. Problems such as isolation, trauma, depression and mental health issues are more easily defined and addressed with someone experienced with the population with whom you are working. In our work, belief systems and cultural myths may be easier to address with a cultural mediator as well.
- Offer professional development opportunities for staff to learn a new language.
- Be stringent in hiring translators. A very short oral and written proficiency test can quickly let you know if your candidate is able to interpret medical language. The Family Healthcare Network in Porterville, CA uses the following test: They ask the candidate to translate the English into Spanish and then the Spanish into English. They do this orally and then administer a longer written and oral test if they pass this simple one:
  - ~ Are you a new patient here or have you been here before?
  - ~ What do you need an appointment for?
  - ~ How may I help you?
  - ~ What symptoms do you have?
  - ~ Who is your appointment with?
- Be patient.

***DON'T:***

- Use medical terms when a patient's ability to understand is in doubt; medical terminology can be difficult to understand even when providers and patients speak the same language. It can be even more frustrating for a patient doing her best to understand what you are saying to her.
- Use staff members who are not fluent in the language as interpreters because they might inadvertently edit or change the message to make sense of it for themselves as well as the patient.
- Use children as interpreters. Children should not be used as interpreters since the message may be improperly relayed. In addition, they may not have the knowledge base to translate concepts like "period" or "menstrual cycle" or "birth control".
- Compromise patient confidentiality. For example, a woman may not want a family member or spouse to be in the counseling session or treatment room. Family members may have their own bias about which decision the woman should make.

***Join NAF at the MARCH for CHOICE!!***

NAF is excited to announce its co-sponsorship of the upcoming national ***March for Choice*** on Sunday, April 25, 2004. The March will begin on the National Mall in Washington, D.C. and will be followed by a rally featuring pro-choice leaders including NAF President and CEO, Vicki Saporta.

As anti-choice forces continue to chip away at abortion rights, we must stand up for our common commitment to *keep abortion safe, legal and accessible.*

NAF's delegation will bring together current and future abortion providers, patients, and supporters. To join NAF's delegation, please RSVP with your e-mail address to march4@prochoice.org.

# Early Abortion in Family Practice

Many family practitioners are interested in exploring the possibility of integrating abortion care into their practices. While some family practitioners have incorporated surgical abortion in their practices through the years, the approval and availability of mifepristone for early medical abortion offers another option. Some would argue this option is particularly well-suited to the model of family medicine, where many women of reproductive age get the rest of their health care. Over the past several years, there has been a growing recognition of the role of family practitioners in providing women with access to the abortion services they need. This is reflected in the work of advocacy and education organizations dedicated to facilitating abortion training and provision by family practitioners and in an increasing body of research on the topic. Below are summaries written by Linda Prine, MD of some recent studies she and her colleagues have conducted regarding abortion care and family practice.

***"Medical Abortion in Family Practice: A Case Series"*** by Linda Prine, MD; Ruth Lesnewski, MD; and Marji Gold, MD. *Journal of the American Board of Family Practice* Vol 16 No 4, 290-295, July/August 2003

This study is a retrospective case series of 236 consecutive medical abortions performed at four urban family practice community health centers between November 2000 and April 2002. Medical abortions followed the evidence-based protocol using mifepristone 200 mg orally followed 24-72 hours later by misoprostol 800 mcg vaginally.

In our series, 236 patients elected medical abortion; 227 patients followed the protocol with known outcomes. Eight (3%) were lost to follow up. 225 out of 227 patients had a successful medical abortion, a 99.2% success rate. One woman had a continuing pregnancy at the follow-up visit and underwent an MVA for completion. Two patients received suction procedures at other sites for unknown indications. One of these patients used her misoprostol as soon as she got home from the office visit at which she took the mifepristone, so she was excluded from the data analysis for not following the protocol. All other women completed the process successfully. There were no cases of hemorrhage requiring intervention and no cases of retained tissue requiring intervention.

Our case series demonstrates that medical abortion is highly effective and safe in a family medicine setting. Outcomes in family medicine are comparable to those in other published studies where a 95-98% success rate has been reported.

This article is available online at http://www.jabfp.org/cgi/reprint/16/4/290.pdf

***"Integrating Medical Abortion Into a Residency Practice"*** by Linda Prine, MD; Ruth Lesnewski, MD; and Rachel Bregman, MD. *Family Medicine*, Vol 35 No 7, 469-471, July-Aug 2003

Changing residency services and curricula is often difficult under the best of circumstances. Our paper describes an innovative approach to adding medical abortion services to a family medicine residency practice. Staff, faculty, residents, and colleagues were surveyed to examine their attitudes toward adding these services. Their concerns were addressed in a structured manner, using a range of educational formats. This experience demonstrated that it is important to address attitudes and knowledge as part of the successful integration of abortion into family practice residencies.

This article is available online at http://www.stfm.org/fmhub/fm2003/jul03/prine.pdf

***"Abortion Training As an Integral Part of Residency Training"*** by Ruth Lesnewski, MD; Linda Prine, MD; and Marji Gold, MD; Letter to the Editor, *Family Medicine*, Vol 35 No 6, 386-387, June 2003

In 2002, fewer medical students matched in family medicine than the year before, continuing a downward trend. Knowing that many medical students seek residency programs that provide training in early abortion, we wondered how this curricular issue might affect programs' match rates. Through a residency program survey we identified 11 family medicine programs that have abortion training fully integrated into their curriculum. Utilizing data from the official statistics of the National Residency Matching Program, we found that these 11 family medicine programs had a 97% fill rate in 2002, as compared to the 79% fill rate in family medicine overall. We conclude that abortion training may attract medical students who seek training in this area, while offering abortion training does not deter student/program matching.

This article is available online at http://www.stfm.org/fmhub/fm2003/jun03/ltte.pdf

***The Access Project: A Resource for Primary Care Practitioners***

*By Linda Prine, MD; Ruth Lesnewski, MD; and Sandy Merrill, MPH*

The Access Project is a non-profit organization dedicated to the integration of early medical and surgical abortion services into primary care. Our web site (www.theaccessproject.org) includes information and strategies for the many challenges that may arise in implementing these services. In addition to the web site, the Access Project has physicians, advanced practice clinicians (APCs) and staff who consult with providers and primary care sites needing advice on implementation issues. Areas for consultation include: staff preparation, clinical protocols, consent forms, patient education, coding and billing, insurance reimbursement, state laws and regulations and other similar concerns. Access Project physicians and APCs also offer Grand Rounds presentations to residency programs and e-mail correspondence and support for all questions that arise. For more information, feel free to contact the Access Project at: accessproject@earthlink.net.

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***Change of Address Requested***

## *LINK TO OUR ONLINE CME/CE PROGRAM AND RECEIVE A FREE GIFT!*

Last fall NAF launched the ***first*** interactive web-based Online Continuing Medical Education (CME) Program on medical abortion for health care professionals. The program is designed to offer health care professionals comprehensive information about the safe and effective administration of medical abortion with five modules focusing on the topics of medical abortion regimens, management of side effects and complications, counseling, ultrasound, and service delivery issues.

Recently, the program was also approved by the Continuing Education Approval Program of the National Association of Women's Health for 6.0 contact hours, including 1.2 hours of pharmacology. We'd like to invite those of you affiliated with a professional organization to extend this valuable resource to your network by linking directly from your organization's website to the Online CME/CE Program at http://www.earlyoptions.org/online_cme/default.asp or to NAF's Early Options site. The first ***twenty people*** who contact us and link your organization's website to either our Online CME/CE Program or to our www.earlyoptions.org website will receive a NAF "thank you" gift packet with resources and specialty items valued at $100!

This is a great opportunity to get this one of a kind resource into your network! Please email us at earlyoptions@prochoice.org and with subject line "Link to Online CME". We look forward to collaborating with organizations whose members and website visitors would find NAF's resources useful.

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### *LEGISLATIVE ACTION CENTER*

With over 270 Members of Congress and 24 state legislatures solidly anti-choice, there are countless opportunities to make your voice heard in policy debates. NAF's Legislative Action Center keeps you informed of all the latest attempts to restrict a woman's right to choose. Contact your representatives on the local, state and federal levels: sign up at www.capwiz.com/naf.

***Be informed, be educated & be active!***