REMAPPING DEBATE
Asking "Why" and "Why Not"

Pro-choice timidity in fighting shortage of abortion providers

Original Reporting | By Heather Rogers | Reproductive health services

March 13, 2013 — As Remapping Debate previously reported, the number of state-based restrictions on abortions has increased significantly over the last two years. Defining a "scarcity" of abortion providers to mean a state where either 60 percent of the women live in a county without an abortion provider, or where there are 200,000 or more people for each abortion provider, we found that fully 32 states were experiencing scarcity as of 2008, the last year for which these data are available.

Several individuals we spoke to when preparing this article urged us, apparently independently of one another, not to run the story out of concern about creating a "backlash."

How are abortion-rights supporters fighting back? More specifically, recognizing that the current environment in many parts of the country is hostile to abortion providers, what are those abortion-rights supporters doing to increase the supply of obstetrician-gynecologists (ob-gyns) who perform abortions?

Remapping Debate's investigation found that the efforts being made, particularly when it comes to providing encouragement for, and training to, ob-gyns already in practice but not yet performing abortions, were severely limited; that progress has stalled in providing training for medical students and for doctors completing their residency requirement; and that there is widespread defensiveness among abortion-rights supporters about engaging in aggressive efforts to organize and set out a "counter-narrative" that could support a major increase in the supply of ob-gyns who perform abortions.

Indeed, despite repeated efforts on our part, no representative of the Planned Parenthood Federation of America, which describes itself on its website as "the nation's leading sexual and reproductive health care provider and advocate," would agree to be interviewed by Remapping Debate. Several individuals we did speak to when preparing this article urged us, apparently independently of one another, not to run the story out of concern about creating a "backlash."

Limited outreach to ob-gyns already in practice

Data from the American Medical Association and from the American Congress of Obstetricians and Gynecologists confirm there are far more ob-gyns already in practice than there are in residency programs. And a study, published last year in the academic journal Family Medicine noted that, while "the majority of abortion training currently takes place during residency and medical school…our study suggests that training later in a clinician's career might yield a higher percentage of abortion providers."

Dr. Barbara Gawinski, a co-author of the study and an associate professor in the Department of Family Medicine at the University of Rochester Medical Center, told Remapping Debate, “There is not the availability for advanced level practitioners” — doctors who are established and treating patients — “to get the training that they need.”

But little is being done to expand the supply of abortion providers from among the large pool of practicing ob-gyns who do not now offer abortion services. Representatives of three organizations that currently provide abortion training to medical school students, hospital residents, and those just out of residency — the Kenneth J. Ryan Residency Training Program and the Family Planning Fellowship Program, both run out of the University of California, San Francisco (UCSF), and the Reproductive Health Education in Family Medicine program, based at Montefiore Medical Center in New York City — neither agreed to be interviewed nor responded to emailed questions on the need to expand training for ob-gyns currently in practice.

The National Abortion Federation (NAF), an organization that does train current ob-gyns, is not ramping up its efforts. Based on its contact with doctors at various professional conferences and meetings, Vicki Saporta, NAF’s president and chief executive officer, said the organization doesn’t perceive substantial interest among mid-career physicians to learn abortion care. “That is not the reality,” she said, adding that mid-career doctors “have chosen not to provide abortion care” primarily because the practices and hospitals where they work don’t allow it and they prefer to avoid conflict. When Remapping Debate asked if NAF did outreach specifically to this group in an effort to recruit them, Saporta said, “If they want to do abortion training they will find their way to us.”

Asked if her organization did outreach specifically to mid-career doctors, the National Abortion Federation’s president said, “If they want to do abortion training they will find their way to us.”

Dr. Debra Stulberg is a co-founder, current board member, and president of the Midwest Access Project (MAP), a small non-profit that provides abortion training, including to practicing doctors. Stulberg believes that “mid-career doctors are an important workforce for reproductive healthcare.” Yet MAP, which provides training for several medical students and several residents each year, was only able to train practicing physicians at a rate of less than one per year from 2007 to 2012.

Stulberg, who also practices and teaches at the University of Chicago, readily acknowledged that these efforts are “not enough,” adding, “We have to turn away interested trainees all the time.” From MAP’s perspective, she said, the problem is finding enough providers who are willing and able to teach those who want to learn. “Our biggest challenge is the training capacity,” she said. Funders who are supportive of abortion rights, she asserted, need to realize that it is not enough to provide services or sponsor advocacy for the here-and-now; they also, she said, have to understand the need “to train the future generations.”

Lisa Maldonado, executive director of Reproductive Health Access Project, a program similar to MAP, agreed that there is a lack of capacity for training doctors already in practice. The solution to that problem, she said, is straightforward: the current shortfall in training capacity "could all be remedied with funding."

Major gaps remain in medical school training

If most ob-gyns already in practice are not being reached, what about medical students? Dr. Jody Steinauer, an associate clinical professor in the Obstetrics and Gynecology and Reproductive Sciences Department at UCSF, and a founder of Medical Students for Choice (MSFC) when she was in medical school 20 years ago, says that a student's intention to include abortion services in her practice upon graduating from medical school has been a significant predictor of who ultimately becomes an abortion provider. Steinauer was the lead author of a 2008 study that found that of practicing abortion providers, 77 percent had gone into residency intending to perform abortions.

> Medical schools that *do* offer abortion education in a student's first two years dedicate less than 30 minutes to the topic, according to Medical Students for Choice.

Nevertheless, major barriers remain to giving all medical students initial experience with the field. Lois V. Backus, MSFC's executive director, said the lack of abortion education in many medical schools is a "huge problem." According to MSFC, even those medical schools that *do* offer abortion education in the first two years dedicate less than 30 minutes to the topic. The group claims that most of this instruction is limited to ethics discussions, and not education and training.

And during the final two years, when medical schools focus on clinical training, less than a third of all medical schools have at least one lecture specifically about abortion, as reported in a 2005 article in the American Journal of Obstetrics and Gynecology, an academic journal.

Backus said that many medical schools are reluctant to teach abortion out of fear of losing public and private funding. She also said that there were instances of students threatening to sue medical schools if they were made to study abortion. Noting that there were subjects other than abortion that some students did not wish to learn, Backus she would like medical schools to take the position of saying, in effect, "Too bad, you're a medical student!'" Instead, she said, medical schools typically accommodate themselves to student resistance rather than incorporating abortion education into the required curriculum.

When MSFC members have been successful in getting a school to include abortion instruction, such progress is often transient. Sometimes MSFC chapters convince their institutions to incorporate abortion instruction into the overall curriculum, but more often they are only able to convince individual faculty members to give lectures on abortion in class. The MSFC chapter at George Washington University

worked for three years to get an instructor to include a one-hour lecture on abortion. When he left, three or four years later, a new teacher came in and cut the lecture. “So the chapter had to reengage,” Backus said, “and spend another two years convincing the new teacher that they really did want that one-hour lecture on abortion.”

Failed promise in residency programs

Residency programs come under the aegis of the American Council of Graduate Medical Education (ACGME), which is the sole accreditation body. In 1996, the ACGME enacted a rule establishing that “experience with induced abortion must be part of residency training.” The rule had an impact: whereas only a small fraction of residency programs routinely integrated the training into their curricula prior to the rule, 50 percent of residency programs do so today (residents retain the ability to opt out).

Why does initial interest in providing services often not translate into practice?

As noted above, the universe of doctors who do provide abortion services is primarily made up of those who went into residency with the intention of offering pregnancy termination as practicing doctors. But it is still the case that a significant percentage of doctors who *do* receive abortion training *don’t* go on to offer the service once they begin taking patients.

Lori Freedman is a sociologist and assistant researcher at the Department of Obstetrics, Gynecology and Reproductive Sciences at UCSF, and the author of the book “Willing and Unable: Doctors’ Constraints in Abortion Care.” She was the lead author of a 2010 study that found that 60 percent of those surveyed had wanted to offer elective abortions after their residencies. Ultimately, however, just 10 percent were doing so.

“There are a lot of problems with integrating abortion into practices,” Freedman told Remapping Debate. “The reasons for policies barring abortions are stigma, fear of lost business through controversy, or people protesting. And sometimes it’s just logistics.” The barriers can range from highly charged political and religious objections to the more mundane. For example, if a group practice or clinic starts offering abortions, this may slow down the number of patients its doctors can see in any given week. “They may not have a huge opposition to it, but it would create a disruption to the flow of the clinic,” Freedman said. “If it’s not a priority and if it’s very easy to send them to Planned Parenthood, why bother?”

In more extreme cases doctors are contractually barred from offering abortions by their employers. Dr. Rebecca Mercier, an ob-gyn based in North Carolina, described the situation faced by a colleague from residency who accepted a position with a large health care employer in the Midwest. Once she arrived, she found out that her employer didn’t offer abortions at its facility, and was surprised to discover that her contract stipulated that she could not perform abortions in her spare time anywhere else. This predicament is not uncommon, leading Dr. Debra Stulberg of the Midwest Access Project to say that, as part of standard abortion training, residents should be taught contract negotiation techniques to ensure they don’t inadvertently or unwillingly sign an agreement that prevents them from providing pregnancy terminations.

Being able to give abortions is “so much harder than people realize because you have to have an entire staff on board with you too,” added Freedman. “You’re kind of swimming upstream if your practice isn’t already doing it, and the entire structure of the clinic and all the assistance you’d need isn’t there yet.” Whether a doctor is working at a group practice that doesn’t offer abortions, or is on staff at a large hospital that bars it, if she can’t provide abortions and she wants to, she’s going to need support in creating that option.

But another 10 percent do not offer the training at all, and fully 40 percent only offer it on an "opt-in" basis, even though the American College of Obstetricians and Gynecologists has found, "The nature of elective or opt-in training places the burden to create a clinical experience on the residents, and prior data show that the majority of residents participate in training when it is integrated whereas a minority of residents participate when it is elective."

A central obstacle to full enforcement of the ACGME's abortion-training requirement is the Coats Amendment, named for Senator Dan Coats (R-Ind.), and passed by Congress as an amendment to the Public Health Service Act of 1996. The Coats Amendment states that governments at all levels "shall deem accredited" any residency program that would otherwise be in noncompliance with abortion-training requirements. In other words, the amendment overrides the ACGME's ability to revoke the accreditation of a program that is not offering abortion training.

Despite the Coats Amendment, however, Dr. Douglas W. Laube, an ob-gyn who has been providing pregnancy terminations since 1970 and is board chair of Physicians for Reproductive Health, asserted that the ACGME has mechanisms of enforcement short of revocation of accreditation that it can utilize to put pressure on non-compliant residency programs. These include issuing citations to programs not following the rule, which could stir peer pressure from other programs to comply, and would flag the institution to potential residents who might consequently decline to go there. Coupled with citations for other problems, Laube said, citations related to abortion training could place a program in probationary status, which in turn could lead to more site visits by the ACGME. Such site visits — essentially audits that are time- and resource-intensive for residency programs to undergo — could, Laube said, encourage more programs to comply.

> The national umbrella organization Planned Parenthood Federation of America neither granted Remapping Debate an interview nor answered emailed questions about its role in facilitating abortion training.

Mary Joyce Johnston, the executive director of the ACGME's Obstetrics and Gynecology Review Committee, and of its Council of Review Committees, responded to Remapping Debate's interview request by referring us to John H. Nylen, the ACGME's senior vice president for administration. Nylen did not respond to our request for an interview, and did not answer emailed questions concerning what the ACGME is doing to enforce its abortion-training requirements.

Potential initiatives

One element of NAF's training involves instruction on how to administer medical abortions using the medication mifepristone (the "abortion pill"). A medical abortion is available to women within the first nine weeks of a pregnancy, and is not a surgical procedure. As such, it has low complication rates. Because it is a medication, doctors are obliged to train in the pharmacology of and protocol for administering mifepristone, but there is no need for the more complex surgical instruction and practice that vacuum aspiration terminations require. Consequently, the medical method allows physicians to readily incorporate abortion into their existing practices. As of 2008, one quarter of all abortions were medical.

New doctors just hired by a hospital or group medicine practice frequently find that their employer does not permit them to provide abortion services, even in their spare time, according to Dr. Suzan Goodman.

While NAF actively sought out doctors to train in mifepristone provision in the early 2000s, when the drug was first legalized in the U.S., Saporta, its president and CEO, said NAF has decreased these efforts in recent years. (Saporta said NAF hopes that mifepristone will be approved in Canada soon, and that when it is, her organization will be ready with updated outreach and education materials for doctors who want medical abortion training.)

Another approach to expanding the number of providers is to make available one-on-one mentors who can support new physicians in offering abortion care.

The UCSF-based Training in Early Abortion for Comprehensive Healthcare (TEACH) program is designed for residents in family medicine (doctors in family medicine practice can, with the proper training, provide abortions, just as ob-gyns do). Dr. Suzan Goodman, executive director of TEACH, said that new doctors just hired by a hospital or group medicine practice frequently find that their employer does not permit them to provide abortion services, even in their spare time. According to Goodman, the new doctors generally do not challenge the employer policy because they are often afraid of jeopardizing their newly acquired jobs — many have student loans, and have just started families and bought their first homes.

The TEACH program has developed a modest network of mentors who can be matched up with new doctors. These mentors can offer advice and strategies for how to introduce abortion services in the setting of a group practice or hospital otherwise resistant to doing so.

Mentors also work with new doctors who do give abortion care, but under stressful conditions, such as being the only provider in a geographical area. Mentors can offer advice on how the doctor can better cope psychologically and in practical terms, including how to build up a supportive nursing and office staff. "These mentoring relationships are so key," said Goodman.

TEACH currently administers its mentorship program with fewer resources than Goodman would like. If TEACH had more funding, she said, it could hire one or more full-time employees to better facilitate the matching of new doctors and mentors, offer greater outreach to recruit mentors, and provide oversight to encourage doctors and mentors to continue to work with one another over time. She also said more money could be used to create resource centers to supply information, including legal advice, to new physicians who have been prevented by their employers from including abortion in their practices.

Lori Blewett, a communication and social studies professor at The Evergreen State College in Washington State, told Remapping Debate that established doctors who provide abortion services should be more vocal in encouraging their colleagues to do the same.

“Are [doctors] really doing all they can to provide a counter-narrative?” Blewett asked, noting that established doctors could use their status to, among other things, speak out on the public health ramifications of the scarcity of abortion providers. They could do this in public statements, at conferences, or through caucuses they create within existing professional organizations, she said.

If doctors don’t speak out, especially to each other, about abortion being a standard, legal part of health care, Blewett said, then “they’re abdicating their responsibility.”

Accommodation or self-defeating muzzling?

Any individual or entity that either provides abortion services or seeks to broaden the availability of abortion education and training can face a backlash. Given this reality, what is the appropriate approach?

To judge from the responses and lack of responses from the people we interviewed, the most popular idea is to do one’s work unobtrusively — to try to stay beneath the radar.

For example, Planned Parenthood of the Rocky Mountains (PPRM), based in Denver, has its Clinical Training Program for medical students, residents, and physicians. But the organization’s spokesperson would not elaborate on the number of students, residents, and practicing physicians it trains, or on the scope of the program overall.

If doctors don’t speak out, especially to each other, about abortion being a standard, legal part of healthcare, then “they’re abdicating their responsibility,” said Lori Blewett of The Evergreen State College in Washington.

The national umbrella organization Planned Parenthood Federation of America neither granted Remapping Debate an interview nor answered emailed questions about its role in facilitating abortion training. And instead of referring us to its own affiliates that offer this clinical training, such as PPRM, it pointed us away from Planned Parenthood, suggesting that we contact other programs it named.

And a leading academic researcher in the field, who had already spoken with Remapping Debate on the record, sent us an email cautioning against the publication of this article. The researcher, who did not want to be identified by name as the author of the email, warned about "the possibility of negative effects of writing about [abortion training]." The email continued: "Drawing attention to training in the media inspires legislators to write and pass training restriction bills. That would cause a lot of problems for training and worsen access."

Indeed, it would appear as though some groups are trying to lower their abortion-rights visibility. Some groups have rebranded themselves. An organization that until last fall was called the Abortion Access Project now goes by the harder-to-decode name Provide. The organization, which works in the South and Midwest, had as its initial mission encouraging doctors already in practice in areas with a shortage of abortion providers to start offering such care. Over the last six years, however, Provide has largely shifted its focus from abortion training to counseling and referral, hoping to draw in doctors and other health care workers who otherwise avoid even talking about abortion to their patients.

On Feb. 12, 2013, Physicians for Reproductive Choice and Health changed its name to Physicians for Reproductive Health. Asked about the change, the organization's director of communications asserted that the word "choice" was "redundant."

Even when it comes to enforcement of training requirements of the ACGME, the residency oversight board, there is not unanimity.

The long-time abortion provider Laube said that the ACGME should "crack down" on ob-gyn residency programs that don't offer integrated abortion training. He considers the opt-in approach to be in violation of the ACGME abortion-training rule because the resident must initiate the training.

But others in the abortion rights world, including Goodman, who runs the TEACH program, have a different view. While Goodman agreed that the ACGME requirements should include abortion training and that the enforcement tools (like the issuance of citations) that Laube described should be employed by ACGME, she emphasized her concern that drawing too much attention to the issue could be "polarizing." She said, "sometimes our efforts go further without the banner" of abortion rights, adding, "We need to be cautionary in our attempts to broaden the requirements so that we don't just elicit more opposition than we started with."

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