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PROFESSION

Abortion training: Hard to get?

Most professional and academic leaders say doctors who want instruction get it, but some residents say finding someone to teach them is easier said than done.

By MYRLE CROASDALE, amednews staff. Oct. 24/31, 2005.

Family physician Jules Marsh, MD, did a year in emergency medicine before switching to family medicine. During both residencies, she set up month-long electives to learn how to perform abortions. Otherwise, she said, she would not have even heard it discussed.

"The status of abortion training in the United States is disturbing," said Dr. Marsh, who finished her training in Tacoma, Wash., this year. "As far as I can remember, not a word about abortion was brought up in medical school and nothing during residency. ... It's like never having heard of a colonoscopy."

Family physician Debra Stulberg, MD, said she had an equally difficult time seeking out training she wanted. She ultimately set up an elective at a Planned Parenthood clinic in Chicago during her family medicine residency. But it wasn't easy.

"I came in knowing I wanted to be trained in the full scope of women's health, so I began setting this up very early," Dr. Stulberg said, who finished her residency in Chicago in June. "I felt I had to reinvent the wheel. I was going to other institutions, in some cases out of state; there were issues about malpractice coverage and getting institutional approval. Luckily, I had a network of attendings in other cities willing to train me, but they had to jump through hoops as well."

The Planned Parenthood clinic where she ended up didn't have a formal program, and it took some convincing to get the physician there to take her in, she said.

While Dr. Stulberg was persistent, she saw other residents put aside their interest in the procedure when confronted with creating their own training program. It makes her wonder how many residents aren't getting the abortion training they want because they don't have time to set up the learning experience.

"When your own training is left in your hands to organize, it just means it doesn't happen," she said. "There are a lot of residents interested in learning the full scope of women's health, but they're not getting the opportunity."

Several individual residents and physicians say that it can be very difficult to obtain abortion training if there is not active support from within individual residents' programs. Consequently, they say, not enough doctors are being trained to meet the public needs for a legal medical procedure.

Most professional and academic organization leaders disagree. They say abortion training is available to those who want it and the education system adequately safeguards the public's needs, while respecting an individual physician's moral or religious decisions.

Training requirements

The American Medical Association leaves members to decide individually where they stand on abortion. AMA policy "encourages education on termination of pregnancy issues," but further states, "any direct or indirect participation in an abortion should not be required."

The Accreditation Council for Graduate Medical Education doesn't require abortion training for family medicine residents, but residents can take it as an elective.

Perry Pugno, MD, MPH, director of medical education for the American Academy of Family Physicians, said although a minority of family medicine programs include abortion in curricula, he disagreed with the perception that gaining such skills can be a problem for residents.

In addition to being able to take an elective, he said, family medicine residents who undergo obstetrics training learn how to do dilation and curettage for women who have miscarried, a procedure he said is equivalent to a first-trimester abortion.

The ACGME requires that all obstetrics and gynecology residents learn how to handle abortion complications. Residents with moral or religious objections may opt out of doing elective abortions. Residents at a hospital with a religious affiliation that prohibits abortion training, or at a hospital that does not offer the procedure, must be provided with an alternative site to train, ACGME requires.

Patrick Duff, MD, a member of the Council on Resident Education in Obstetrics and Gynecology at the American College of Obstetricians and Gynecologists, said these requirements are sufficient to ensure that if a woman's life is at risk, there will be a skilled ob-gyn to end her pregnancy.

"I don't think there's a problem of our future generation of ob-gyns being unable to treat women adequately," he said.

As a professor at the University of Florida College of Medicine in Gainesville, Dr. Duff said pregnancy termination techniques are among the formal learning objectives for residents. While residents choose whether they participate in an elective abortion, he said the dilation and curettage of the uterus after a miscarriage or fetal death is the same procedure as a first-trimester abortion, so all residents get practice in the procedure.

If there's a shortcoming in training, it would be for second-trimester surgical abortions, the dilatation and evacuation procedure, said Dr. Duff. However, he strongly disagreed with the contention that access to abortion training was a challenge for residents.

"I don't think this is a big issue at all," Dr. Duff said. "I go to our national meetings, and this topic has never been a big issue. It's clearly stated in our learning objectives that residents need to learn how to do these procedures. You have to deal with patients with an unexpected stillbirth or miscarriage. You need to know an acceptable technique for accomplishing a first- and second-trimester delivery."

Some question training level

Ob-gyn Carolyn Westhoff, MD, a member of the Assn. of Reproductive Health Professionals board of directors, disagrees with the assertion that a doctor trained in dealing with a miscarriage would be equally skilled at a first-trimester abortion.

"It's not the same procedure as a D&C;," Dr. Westhoff, whose organization represents physicians and other health professionals in reproductive health, said. For example, she said, most miscarriage patients are already dilated, while those seeking abortions are not.

According to 1998 data from the National Abortion Federation, a professional association of abortion providers in North America, a majority of ob-gyn residencies said they offered first- and second-trimester abortion training. But researchers suggested that number may be too high.

For example, NAF researchers said an official on the ACGME's Residency Review Committee for Obstetrics and Gynecology in 1997 estimated that 35% of residents completing their fourth year of ob-gyn training had not performed a single abortion.

As a result, "there is a shortage of available [abortion] providers," said Dr. Westhoff, a professor at Columbia University Medical Center in New York.

Those who have led abortion care have been physicians at freestanding clinics, not teaching hospitals, she said. The situation hasn't changed much since abortion first became legal, and large medical schools and teaching hospitals have not treated abortion as an important area of training, she said.

Those who say there's a shortage of doctors doing abortions often cite statistics from the Alan Guttmacher Institute, a nonprofit organization focused on sexual and reproductive health research and policy analysis. The institute reports that the number of clinics, physician offices and hospitals performing abortions declined 11%between 1996 and 2000, with 1,819 institutions offering the procedure in 2000. The institute cites physician retirement, increased restrictions on abortion and a lack of training for new doctors and students.

Those who say the medical profession is training enough physicians to meet the public's reproductive needs point to the 41,000 ob-gyns practicing in the United States and the 4,665 ob-gyn residents in training during the 2003-04 academic year. While moral objections could mean that only a fraction of these physicians choose to do elective abortions, if a woman's life is at stake, these doctors would know how to end a pregnancy safely, said ACOG's Dr. Duff.

Doctor takes issue to court

In addition to anecdotal stories of abortion electives being difficult for family physician and ob-gyn residents to set up, Arizona ob-gyn J. Christopher Carey, MD, in August sued the Maricopa Medical Center in Phoenix, the Maricopa County Board of Supervisors and others alleging that the board fired him as the culmination of a yearlong effort to stop residents from doing abortions at a Planned Parenthood facility.

The county and Dr. Carey declined to comment on the ongoing legal battle. According to the lawsuit, the Maricopa County Board of Supervisors fired Dr. Carey from his position as ob-gyn residency program director at Maricopa Medical Center in September 2004 because he included his wife's real estate agent business card in an information packet for new residents.

But in the lawsuit, Dr. Carey claims an investigative committee cleared him of this charge as well as allegations of sexual harassment, performing illegal abortions and discriminating against pro-life employees.

In 2003, the county and medical center "began a campaign to eliminate abortion training previously provided by Maricopa County," Dr. Carey states in court documents. "They nullified an affiliation agreement with Planned Parenthood, rendering Phoenix Integrated residency program in obstetrics and gynecology in noncompliance with the ACGME standards for accreditation."

The ACGME confirmed that the ob-gyn program at the Maricopa Medical Center in Phoenix was scheduled for a site visit but would not specify why. The ACGME does not comment on investigations.

If a hospital were to deny residents access to abortion training, it would be open to disciplinary actions, including loss of accreditation, according to ACGME program requirements.

Ed Perrin, MD, a family physician in Phoenix and an active member of Planned Parenthood of Arizona, said the situation in Maricopa County was symptomatic of what's taking place nationally. "This is a deliberate effort to restrict abortion training, and it's part of a larger national effort that's using this site as a test case," he said. "What it comes down to is a question of academic freedom. We have a local board with certain beliefs contravening national policies set by medical professionals."

Dr. Perrin said political pressure is making it harder for family medicine and ob-gyn residents to get abortion training. He also said hospital mergers with Catholic institutions further complicate access to training.

A spokesman for the Catholic Health Assn. said teaching hospitals must comply with ACGME standards. He said the CHA does not make policies regarding residency programs.

Dr. Duff also was adamant that U.S. medical education was not leaving women without adequately trained physicians.

"I don't think anyone could make the argument that residents don't learn all the components of abortion techniques," he said.

ADDITIONAL INFORMATION:

Abortion timeline

1973: U.S. Supreme Court ruling in *Roe v. Wade* gives women the right to an abortion.

1992: Supreme Court upholds the abortion rights in *Planned Parenthood v. Casey,* and says states can enact restrictions that do not create an "undue burden" for women.

2000: Supreme Court declares Nebraska's law criminalizing abortion by dilatation and extraction -- what lawmakers call "partial-birth" abortion -- unconstitutional in *Stenberg v. Carhart* because it lacks an exception to protect the woman's health and imposes an undue burden.

2003: The 6th U.S. Circuit Court of Appeals in Cincinnati rules that Ohio's ban on dilatation and extraction meets U.S. Supreme Court thresholds.

2003: Congress passes and President Bush enacts the Partial Birth Abortion Ban Act of 2003, nearly identical to Nebraska's law.

2004: Three federal district court judges in three separate cases declare the Partial Birth Abortion Ban Act of 2003 unconstitutional; government appeals.

2005: 8th U.S. Circuit Court of Appeals in St. Louis declares the Partial Birth Abortion Ban Act of 2003 unconstitutional; government appeals.

June 2005: U.S. District Court for the Southern District of Mississippi declares unconstitutional a law banning abortions after the first trimester in any facility other than a licensed hospital or ambulatory surgical facility.

September 2005: U.S. District Court for the Eastern District of Michigan rules unconstitutional a Michigan law defining birth as the moment when any part of the baby emerges from the birth canal, saying it is confusing, vague, and places an undue burden on a woman's right to choose.

October 2005: Arguments in two cases challenging the Partial Birth Abortion Ban Act of 2003 law are scheduled in separate appeals courts.

Sources: The Alan Guttmacher Institute, news accounts

By the numbers

- 93% of abortions were provided in clinics in 2000, as opposed to hospitals or physician offices.
- 87% of U.S. counties were without an abortion provider in 2000.

- 34% of U.S. women age 15 to 44 lived in counties where abortion providers were not available, in 2000.
- 31% of the nation's 276 metropolitan areas had no clinic, hospital or physician office providing abortions in 2000.
- 24% of pregnancies in 2000 ended in abortion (not including miscarriages).
- 11% fewer clinics, physician offices and hospitals were performing abortions in 2000 than in 1996; 1,819 facilities offered the procedure in 2000.
- 5% fewer abortions were provided in 2002 than in 1996; 1.29 million abortions were performed in 2002.

Source: The Alan Guttmacher Institute

Government funding

- Federal Medicaid funds may not be used to pay for abortions except when the woman's life is endangered by a full-term pregnancy or in cases of rape or incest.
- 17 states use public funds to pay for abortions for some poor women.
- 14% of all abortions in the United States are paid for with public funds, primarily state tax dollars.

Source: The Alan Guttmacher Institute

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