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# Shoot the Abortionist Twice: the Crisis in Abortion Training in the United States

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Shoot the Abortionist Twice: the Crisis in Abortion  
Training in the United States

A Thesis Submitted to the Yale University School of Medicine in Partial  
Fulfillment of the Requirements for the Degree of Doctor in Medicine

by  
Dara Beth Arons  
2006

Abstract:

Shoot the Abortionist Twice: the Crisis in Abortion Provision in the United States. Dara Beth Arons. Department of History of Medicine, Yale University, School of Medicine, New Haven, CT.

The purpose of the paper is to examine where and how abortion training takes place throughout medical education in the context of a current shortage of abortion providers in the United States. The study was conducted using internet search engines Scopus, Academic Search, History of Science and Technology, and OVID, with keyword searches including “abortion,” “medical education,” “residency training,” and “family medicine.” Personal interviews were also conducted with leading abortion educators and researchers. The paper addresses the training of potential abortion providers, during medical school and residency education in obstetrics and gynecology and in family medicine. Through an examination of where abortion providers practice in the United States, how medical professionals gain exposure to abortion throughout their education, and how the medical community addresses the matter, this paper demonstrates how the omission of exposure to this prevalent procedure throughout medical education contributes to the shortage of abortion providers in this country today. For all women in the U.S. to have equal access to full reproductive healthcare, more physicians must be trained in abortion care. Moreover, as the sole primary care providers in much of the country, family physicians are best equipped to resolve the shortage.

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This work is dedicated to abortion providers past, present, and future.

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## Introduction

*As the national debate over abortion smolders on, occasionally erupting into actual flames, a gradual awareness has grown that American women's right to a safe medical abortion may be threatened less by political or ethical debates than by a shortage of physicians trained to perform the procedure.(1)*

Half of all pregnancies in the United States are unintended. Of these, half will be terminated.(2) Almost 1.3 million abortions are estimated to have been performed in the United States in 2002, the last year for which these data are available. For women between the ages of 15 and 44, 20.9 out of 1,000 had an abortion in that year.(3) This translates into 60 abortions per 100 women throughout their reproductive lives. This rate is higher than that of most other industrialized countries.(4)

The elective abortion rate has been steadily declining since its 1982 peak of 29.3 per 1,000 women of reproductive age. When abortion first became legal in 1973 the rate was 16.3.(5) The recent decline in abortions might be attributed to teenagers' decreased sexual activity or increased access to contraception, but teenagers account for less than one fifth of all abortions. Another possible explanation for the decline is expanded Medicaid eligibility for family planning services, including contraception, in select states. Throughout the 1990's, however, fewer women of reproductive age were eligible for Medicaid, while more became uninsured. Thus fewer women had access to abortion, decreasing the abortion rates.(6) Support for this reasoning is data from the 1990's, which

demonstrate that rates of abortion decreased overall but increased among poor women and those on Medicaid.(7)

One might hope that abortion rates are falling because of a decrease in unplanned and unwanted pregnancies. With education programs focusing only on abstinence and some pharmacists refusing to fill contraceptive prescriptions, it seems unlikely that the need for abortions has declined. Instead, the decrease in abortions in this country may reflect the decrease in access to abortion provision. It is possible that more women are continuing undesired pregnancies because they cannot find a doctor who will help them in time.

In 1993, half of all medical students in the United States received a comic book style flier titled “Bottom Feeder” in their mailboxes with caricature-like depictions of abortion providers. “What would you do if you found yourself in a room with Hitler, Mussolini, and an abortionist, and you had a gun with only two bullets?” one entry in the pamphlet queried. The response: “Shoot the abortionist twice.”(1) Although the American Medical Association filed a federal restraining order against the Texas anti-abortion group that had used medical students’ addresses to distribute their propaganda, the point had been made. Why would any medical student actively pursue training to become such a loathed character?

This paper addresses the training of abortion providers, during medical school and residency education in obstetrics and gynecology as well as in family medicine programs. Through an examination of where abortion providers practice in the United States, how medical professionals gain

exposure to abortion throughout their education, and how the medical community addresses the matter, I will show that the omission of exposure to this prevalent procedure throughout medical education results in the shortage of abortion providers in this country today. For all women in this country to have equal access to this important control over their reproductive lives, more physicians must be trained in abortion care. Moreover, as the sole primary care providers in much of the country, family physicians are best equipped to resolve the shortage.



## History of Abortion Provision

*The medical profession organized to criminalize abortion in the mid-nineteenth century and to oppose those very laws a century later.(8)*

Until the first half of the nineteenth century, abortion up to the point of quickening, when the mother was able to feel fetal movements, was legal and socially accepted in the United States. At this time, midwives were the main birth attendants and abortion providers.(8, 9) With the creation of the American Medical Association (AMA), in 1847, physicians began an organized lobby against abortion in order to gain “professional power, control medical practice, and restrict their competitors,”(8) midwives and other non-licensed would-be abortion providers. Their platform was also driven by a eugenic fear that immigrants would out-populate white Protestants who underwent the majority of abortions at the time.(8, 9)

Medical training soon became standardized in the United States with the affiliation of medical schools with universities, beginning in the 1870’s. By the beginning of the twentieth century, the AMA had almost complete control over all medical training in the country as a result of the Flexnor Report, which “urged stricter state laws, stronger standards for medical education, and more rigorous...certification to practice.”(9)

Owing in part to the powerful AMA, by 1900 abortion was illegal in almost every state, with exceptions for medical necessity left to the discretion of

the physician.(9) The result of this nation-wide abortion ban was a marginalization of abortion providers. At first, most doctors would perform pregnancy terminations for their patients in private. At that time the patient wielded substantial financial power over her physician and could threaten to seek care elsewhere or malign a doctor's name, ending his career, if a physician seemed reluctant to interrupt a pregnancy. But shortly after the turn of the century, a second wave of anti-abortion outcry resulted from the beginnings of specialization in medicine. Obstetricians wanted to maintain control over abortion, wresting it from the generalists.(8) The origin of the notion that only obstetricians and gynecologists should be responsible for abortion was born in this historical moment.

Derogatory images of the abortion provider also emerged in this era as abortionists were seen as “vampires”, “blacken[ing]” the profession.(8) These perceptions were linked to cultural changes that made abortion less popular among physicians and other men of power. During the Depression abortion rates soared as doctors sympathized with their patients who could not afford to feed another mouth. Demand for abortion continued in World War II as women moved into the workforce. But in the late 1940s, after the war, a societal drive for women to return home and retrieve their roles as mothers emerged. The nationwide desire for more children, combined with the cultural milieu of McCarthyism, created a ripe breeding ground for the persecution of abortionists.

Physicians soon became co-conspirators with police in upholding the law by searching out illicit physicians and the women on whom they operated.

The decision to perform an abortion was removed from the privacy of the physician's office. Instead, hospital committees were empowered to decide whether each abortion-seeking woman's case was warranted. After the advent of these committees, abortion evolved into the dangerous, expensive, illegal 'back-alley' undertaking that brought women in droves to hospitals for treatment from 'botched procedures'. As mortality from both illegal practitioners and self-inflicted abortion attempts soared (an estimated 5,000-10,000 deaths annually resulted from illegal abortions in the middle of the twentieth century (10)), the medical community could no longer ignore the abortion issue.

It was this final consequence of criminalization, the overfilled septic abortion beds in hospitals, that forced the medical establishment to speak up again, one century later, this time in favor of legalization, in the interest of the welfare of women risking their lives to avoid unwanted pregnancy.(8) In this new climate, physician organizations, including the AMA and the American College of Obstetricians and Gynecologists, and women's right groups worked together for repeal of the abortion laws.(9) On January 22, 1973, in the case of *Roe v. Wade*, the Supreme Court of the United States found states' anti-abortion laws to be unconstitutional in their violation of the privacy rights of women and the rights of their doctors "to practice medicine without undue interference."(8) *Roe v. Wade* protected from state law the decision to terminate a pregnancy up to the point of viability (when the fetus can survive outside the womb), and after

viability, as needed, in order to protect the health and life of the woman.(10)  
Once again abortion was made legal throughout the United States.

Almost immediately after the passage of Roe v. Wade, abortion opponents set to work to weaken its power. Since then, many states have passed laws designed to restrict and limit women's access to abortion. Further, in 1992, in the case of Planned Parenthood v. Casey, the U.S. Supreme Court scaled back on Roe's protections of abortion before viability (currently around 24 weeks of pregnancy), allowing states to regulate abortions after the first trimester (14 weeks gestation) and before viability in order to protect the health of the woman. After viability, states have the right to ban abortions, as long as exceptions for the life and health of the mother exist.(10) More recently, during the writing of this paper, the governor of South Dakota signed into law a bill banning almost all abortion procedures in that state. Whether this law will pass uncontested is unknown, but its existence, along with similar bans in at least four other states, calls into question the security of legal abortion in the United States.

This paper, however, will not address the multiple attacks and further weakening of Roe v. Wade that have occurred and continue to occur daily, in doctor's offices, at the pharmacy, in court rooms across the country. Instead, this paper addresses the other force that prevents women from receiving the care they seek: the lack of experienced, trained abortion providers.

As I will show, the right to legal and accessible abortion, the result of a century-long struggle during which many women lost their lives, is now

threatened by a new adversary. In order for abortion to be available to all women who request it, trained providers must practice in all parts of the country where women of child-bearing age reside. Without trained practitioners, the law is meaningless.

## Abortion: How Many, Where, and Who

*Women who have abortions are our neighbors, friends, mothers, sisters and daughters.*(4)

At the current rate, one in three American women will have had an abortion by the age of 45.(11) It is the most common procedure performed on women. Just over half of all women having abortions are under 25 years old; less than one fifth are younger than 19. Abortion rates of African American women are three times that of white women; those of Hispanic women are more than double that of white women. More than 60 percent of pregnancy terminations are performed on women who have had at least one child.(2)

The number of abortions in this country is more than double that of hysterectomies, the third most common procedure performed on women. One in four women is expected to have a hysterectomy before age 60, with 600,000 performed yearly.(12) The second most common procedure for women is Cesarean section, with a rate of almost 30 percent in 2003, when just over four million births were registered.(13) For comparison to men, the most common procedure performed is circumcision, with a rate, in 2003, of 56 percent for the approximately two million males born that year.(14) For both cesarean and circumcision, those rates calculate to 1.1 million procedures a year, slightly fewer than the recorded number of abortions.

The most updated information on abortion is available from a survey conducted by the Alan Guttmacher Institute, a non-profit organization devoted

to education and research about reproductive health issues. From 2001-2, the Institute conducted the 13<sup>th</sup> survey of its kind, collecting abortion statistics for the United States.(6) Data from the Centers for Disease Control and Prevention (CDC) is also available through 2001, but as the authors of the Guttmacher study point out, the CDC data is incomplete for many states and missing from three states. In order to obtain estimates for abortions in 2001 and 2002, the authors of the Guttmacher study used data from their 2000 survey and correlated it with the CDC data from 2000 and 2001 to produce incidence estimates.(3)

Regarding geographic distribution of abortion procedures in the United States, the two states with the highest rates were New York and New Jersey, with abortion rate defined as number of abortions per 1,000 women of childbearing age. Those two states had rates of 39.1 and 36.3, respectively, compared to the nationwide average of 21.3. The next highest states, with their rates listed in parenthesis, were Nevada (32.2), Florida (31.9), Delaware (31.3), and California (31.2). By region, the highest average rates were in the Northeast, with a regional rate of 28.0, and the West, where the rate was 24.9.

On the other end of the scale, the rate in the South was 19.0 and that of the Midwest was 15.9. South Dakota, Kentucky, and Wyoming had the lowest proportions, with rates of 5.5, 5.3, and 1.0. Other low numbered states were Idaho, Mississippi, Missouri, Utah, and West Virginia, with rates ranging from 6.0-7.0.

Most states experienced a decline in rates of abortion between 1996 and 2000. Some rates declined more steeply than that of the national average, the most extreme examples being Kentucky and Wyoming. As the national rates declined by five percent, that of Kentucky fell by 44 percent, while the Wyoming rate dropped by 64 percent. These numbers mean less when describing states with small absolute numbers of abortions. For example, a drop for Wyoming from 280 abortions in 1996 to 100 in 2000 has a much more dramatic effect on the percentage change than a similar drop for a state like Washington, which experienced a decrease of 140 abortions over the same time period. Washington's percentage change was only three percent because absolute numbers were in the 26,000's. Therefore among the states reporting more than 10,000 abortions, the most dramatic declines in rate were Massachusetts with a decline of 26 percent and Missouri with a decline of 27 percent.

Fifteen states showed an increase in abortion rate over that four-year time period. The highest increase was Delaware, with 5,440 abortions in 2000, translating to a 31 percent increase in rate. But Kansas, with an increase of 15 percent, showed the greatest increase in states with over 10,000 abortions. Part of this increase may be a shift in abortion provision in the Kansas City area that resulted in an increase in recorded number of abortions in Kansas with a complementary decrease in numbers recorded for Missouri. The absolute numbers of abortions in the area may not have changed substantially during this time period.



The other states with greater than 10,000 abortions and increased rates were Florida, Maryland, New Jersey, North Carolina, Oregon, and Tennessee. Those with fewer than 10,000, with increased rates, in addition to Delaware, were Idaho, Iowa, Maine, Nevada, New Mexico, North Dakota, and Rhode Island. As the authors were looking at both periods between 1992-1996 and 1996-2000, they could not see any clear trends in abortion rate increases or decreases by state.(6)

Ninety-nine percent of abortion facilities performing more than 400 procedures a year are located in metropolitan areas.(6) Fewer than seven percent of all sites where abortions are performed are hospitals.(15) This is probably due to the increasing number of hospitals owned and run by religious administrations. It may also be a legacy of *Doe v. Bolton*, the Supreme Court decision passed alongside *Roe v. Wade*, which outlawed hospital abortion committees. This returned the decision to terminate a pregnancy to the patient and her physician.(8) Perhaps, for hospital administrators accustomed to creating strict practice schematics that leave little room for individual physician decision-making, this seemed too much autonomy to grant individual doctors. Hospitals may simply want to avoid the controversy the issue engenders by not allowing abortions within their walls. Regardless of the reason, the fact that more than 90 percent of abortions occur in clinics and private offices contradicts what obstetricians and gynecologists envisioned just before abortion was legalized in 1973. They imagined abortion care would take place in hospitals, like all surgical procedures at the time.(16)

## Abortion Techniques

*[T]he most crucial ingredient for insuring the future of abortion services globally is health professionals adequately trained in abortion techniques.(17)*

There are many options available for pregnancy termination. Early abortion comprises those taking place in the early part of the first trimester, up to about nine weeks. The main surgical option at this stage is vacuum aspiration, either manually with a handheld syringe, or using an electric pump, both evacuating the uterine contents.(18) This procedure is also called suction curettage, vacuum curettage, or uterine aspiration, and is also commonly used to treat incomplete abortion in the case of miscarriage.(19)

Medication abortion, which has been available in the United States since 2000, is a newer option. This is most frequently accomplished through oral administration of Mifepristone, a progesterone antagonist, which causes the gestational sac, embryo, or fetus to detach from the uterine wall.(20) Misoprostol, a prostaglandin, is then administered to begin uterine contractions. Administration varies, with either a provider or the patient inserting Misoprostol vaginally (when the Mifepristone is ingested), or the patient taking it buccally (holding it in the cheeks until it dissolves) the following day. Other regimens include the use of Methotrexate, orally, followed by Misoprostol, or Misoprostol alone.(19) Patient preference is an important factor in deciding abortion technique, as some women prefer the less medicalized, more private

experience of medical abortion, which takes place at home. Others want the efficient, quick surgical procedure, without the waiting that medical abortion involves. The medical procedure involves more bleeding and cramping, and can last from hours to days for the uterine contents to pass completely.

For all medical abortions, as with the surgical procedures, a follow-up visit is required to ensure the abortion is complete. Up to nine weeks gestational age, the procedure has a one percent chance of failure with a three to five percent chance of incompleteness. In these cases, the patient requires a surgical procedure for completion.(20)

Late first trimester abortions constitute those from nine to fourteen weeks' gestation. Electric vacuum pump is the most common surgical procedure, with the use of cervical dilation via mechanical or osmotic dilators; pharmacologic agents are sometimes necessary.(18) By convention, the same procedure, when performed after 13 weeks gestation, is called Dilation and Evacuation (D & E).(19)

Second trimester abortions are performed mostly in cases of fetal anomaly, maternal health problems, and on a disproportionate number of younger women. Many women opt for general anesthesia with these procedures. Historically, abortions after the first trimester were accomplished through labor induction. Now D & E is far more common. Cervical dilation is usually achieved with Laminaria, an osmotic dilator, inserted the day before the procedure. Misoprostol is also used. The uterine contents are either extracted with forceps or with a vacuum, depending on the provider's preference and

gestational age and size.(19) In addition, the medication abortion regimen can be used safely up to 24 weeks gestational age, although at later stages of pregnancy, the patient is kept under observation instead of being sent home to abort.(20)

The risk of complication increases with more advanced gestational age. In fact, although mortality is less than one in 100,000 for abortion (compared with 9.2 for death due to childbirth),(21) almost 90 percent of those deaths could be avoided if women having abortions after eight weeks pregnancy had their procedures earlier.(19)

## Where the Providers Are

*Almost half of the women having abortions beyond 15 weeks gestation say they were delayed because of problems in affording, finding or getting to abortion services.(2)*

Just before abortion was legalized in the United States in 1973, a statement in the *Journal of Obstetrics and Gynecology* by 100 professors in that specialty predicted that separate clinics for abortion would not be necessary because merely half of the obstetricians in the country could fulfill the abortion needs of women in hospitals.(16)

In 2000, 1,819 providers reported performing at least one abortion. This number represents a decline of 11 percent from the previous survey of 1996, which had revealed a 14 percent decrease over four years. This decline is attributed to providers retiring with fewer new physicians becoming abortion providers to take their places. One 1997 survey of obstetricians and gynecologists providing abortions found that 57 percent were over 50 years old. The decline in providers offers the best explanation for why the rates of abortion have dropped in the past twenty years.(6) Just as women are risking second trimester abortions due to difficulty with access, many more may be continuing unwanted pregnancies because they can't find providers in time. Almost 90 percent of all US counties were without an abortion provider in 2000. More than one third of all women of reproductive age live in those un-served counties.(2)

Retirement of providers is not the only reason for the shortage. Some researchers claim providers stop performing abortions because of dissatisfaction with the work, which many consider technically unchallenging.(22) The history of violence against abortion providers has also been a deterrent, causing some existing providers to quit their abortion practices for fear of harm to themselves or family members.(1) Many doctors also admit the fear that they will lose their patient base if they perform abortions, making it a financial issue as well.(23) Regardless of the reasons, there are fewer providers now than there once were.

State variability, as with abortion data, exists for providers as well. In Alabama, Idaho, and Iowa, there was no change in number of providers between 1996 and 2000. For nine states: Arkansas, Connecticut, Delaware, Hawaii, North Dakota, Pennsylvania, Rhode Island, South Dakota, and Texas, the number of providers increased. The Dakotas both saw a 100 percent increase from one provider to two. For the remaining 38 states, the number of providers decreased.

As with change in abortion rates, and as evidenced by the Dakotas, absolute numbers often give more descriptive information than do rates of change. The states with the largest absolute increases in number of providers were Connecticut, with an increase from 40 to 50, Hawaii, with providers up from 44 to 51, and Pennsylvania, which jumped from 61 to 73. The authors explain some of those increases may be false, as they resulted from recording, in 2000, providers who may have been inadvertently overlooked on the 1996 census.

The two states with the largest number of providers, California and New York, saw the largest absolute decreases. California's provider census fell from 554 in 1992 to 492 in 1996 to 400 in 2000. New York, similarly, lost 23 providers in the first four years and then an additional 32 providers to drop to 234 in 2000.

By county, as mentioned above, there is a discrepancy between where abortion providers do and don't practice. And, as with abortion rates, there is great variability in provider shortages, depending on location. In the Northeast, only 50 percent of counties do not have an abortion provider. In the West, this number is almost 80 percent. The South and Midwest fare most poorly in terms of access with greater than 90 percent of counties in both areas without a provider. Additionally, Idaho, Montana, Utah, and Wyoming are comparable to the South and Midwest in terms of provider shortage.

These numbers are only meaningful when examined with census data about women of childbearing age. Overall, one third of women between 15 and 44 lived in the 87 percent of counties without a provider in 2000. When examined regionally, nearly half of all childbearing women lived in counties in the South or Midwest without an abortion provider. In the Northeast and West, less than 20 percent of women lived in counties without access to abortion services. This data do not paint a clear picture, however, as providers in adjacent counties might be very accessible for women living in counties without services. Similarly, a physician might provide abortions in a private practice,

without advertising beyond her patient base, making this care less accessible to women in the area.(6)

An examination of the location of providers by locale is also telling. Almost all providers performing more than 400 abortions a year practice in metropolitan areas.\* Physicians performing this many abortions would be more likely to advertise and accept patients without a referral. Just six percent of all providers, regardless of abortion numbers, practice in rural areas throughout the country. In the entire state of North Dakota, for example, women can find abortion services in only one clinic to which the physicians fly from other states to provide care.(24)

The numbers are not declining in all arenas. The proportion of abortion providers performing very early abortions, of less than four weeks gestational age, has increased dramatically, from seven percent in 1993 to 37 percent in 2000.(2) This is probably due to the use of medication abortion. Additionally, there has been a recent increase in the use of vacuum extraction combined with ultrasonography to ensure complete uterine evacuation.

Again, as with abortion rates by state, no trends were evident in terms of provider decreases or increases over the eight year period. Although the percentage of counties without a provider had changed little from the 1996 data, it was higher than the 77 percent recorded from 1973, when abortion became legal.(6) It is helpful to note that in 1973, 800,000 legal abortions were

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\* “The general concept underlying Metropolitan Areas is that of a core area containing a large population nucleus together with adjacent communities having a high degree of economic and social integration with that core.” From the March 1995 Standard for Metropolitan Areas, developed by the National Institute of Standards and Technology and approved by the Secretary of Commerce for Federal use. <http://www.itl.nist.gov/fipspubs/fip8-6-0.htm>, accessed January 6, 2006.



recorded.(25). Although the number of abortions has increased by more than 63 percent over thirty years, the number of counties with abortion provision has decreased by 13 percent during that same time.

It is important to remember that a complete tally of all abortion providers is nearly impossible. Many providers work in more than one clinic, some in more than one state, making an exact number difficult to obtain without counting the same physician twice. Some providers work privately and do not have an affiliation with any national organization. Fear of violence against providers must also be taken into account as another reason they might wish to remain unidentified. Inherent in the nature of abortion research is the recognition that not all numbers can be known, and some providers will choose not to participate.(22)

Interestingly, the problem of access for rural and poor women is not a new trend. As early as 1976, just three years after abortion became legal, this trend was evident in a study on abortion training in obstetrics and gynecology residency programs. Surveying program directors, the authors learned how many residents were training in abortion procedures. They were also able, through director commentary, to analyze the nationwide trends in abortion provision. Even thirty years ago, abortion was available and accessible to women located in or near major urban areas. But women living in rural locations were often very far from these services.(26)

For the most part, family doctors are the health care providers in these underserved areas. Looking at data from 2000 in the state of Maine gives an

example of how integral family physicians are to obstetrical and gynecologic care in rural areas. In Maine, there are four times as many family doctors as obstetrician gynecologists. An examination of patient populations seeing each type of provider reveals that the family physicians see a much greater proportion of Medicaid patients than do the obstetricians. Knowing that more women in this population are likely to seek abortion care than in groups of women in higher socio-economic status, it would make sense for more family providers to offer abortion services as they are serving these populations.(27) It is important to note that Maine is located in a part of the country that does not depend on family physicians to the same extent as other areas. This data would be more exaggerated if examined in a Southern or Midwestern state.

In looking at care provision nationwide, counties are designated Primary Care Health Personnel Shortage Areas (PCHPSA) if they have a population to provider ratio of greater than 3,500 to one. For these statistics, primary care includes family practice, general pediatrics, general internal medicine, and obstetrics/gynecology. Data from 1995 find that for counties that do not meet the provider shortage requirements, 58 percent would become shortage areas if the family practitioners were removed from the tally. Of the counties that, similarly, would become PCHPSA if any of the other primary providers were excluded, the large majority fall into the first accounting as well. In other words, 2,298 counties in the United States depend on family physicians to prevent them from becoming shortage areas. Looking at it from the other direction, if those counties lost all general providers except for the family

practice doctors, less than one tenth of them would fall into the PCHPSA designation. Family doctors are providing the majority of care to patients in areas where few physicians practice.(28) Family medicine physicians are a logical choice for abortion provision because of their location in the rural and underserved communities that are most lacking in abortion care. For poor and rural women, family medicine physicians are often the only healthcare they can access.(15)

## Abortion Training in Family Medicine Residency

*[F]amily physicians, with their counseling skills and emphasis on caring for the patient in the context of her life and family, are able to offer more supportive abortion care than other clinicians.(29)*

In 1969, with state funding and unprecedented federal financial support, family practice became the twentieth medical specialty in the United States. It was established as a response to the perceived failings of highly specialized academic medicine. Future family medicine providers were expected to fulfill the unmet primary care needs of rural, inner-city, and even middle-class communities by providing care to “geographically underserved areas throughout the nation.”(30) Now, more than any other specialty, family medicine providers practice geographically in proportion to the population of the United States.

Family medicine doctors are well-suited to be abortion providers because, in addition to their geographical location, they also provide the type of patient-centered holistic care that women need most during difficult medical decision-making involving their reproductive lives.(29) “Family physicians have special skills in counseling and patient support that are useful during an abortion.”(31) They also are better trained to facilitate communication between family members about the decision to terminate a pregnancy.(32)

Women seeking an alternate physician for their abortion are likely not to tell their primary doctor about the procedure.(31) If the primary care provider were to be the abortion provider too, she could counsel the patient about

preventing further unintended pregnancies and offer contraception with follow up. Although the obstetrician performs these tasks as well, the primary care provider is likely to be a more consistent health care provider to patients in many parts of the country, particularly rural areas. Although the realm of abortion care has traditionally been covered by obstetricians and gynecologists, the family medicine doctor is better situated than specialists who may see the abortion patient only once.

A 1994 survey of providers in rural Idaho, the state, at the time, with the second lowest abortion rate in the United States, found that half of all family physicians were performing equally, if not more complex, surgical procedures than abortion, but only two out of 114 provided abortions. Although they had access to the services and support they needed to perform the procedure, almost none were choosing to perform it.(33) Many regard the procedure itself as quite easy, hardly requiring any skill or practice at all, so the decision not to provide is clearly not a technical one.(34, 35)

In 2002, the Society of Teachers of Family Medicine (STFM) Group on Abortion Training and Access surveyed all 480 residency programs in family medicine in the United States. They asked residency directors about abortion training offered by their programs. They then validated the responses of the 21 program directors who indicated that abortion training was “an integral part of residency training” by questioning chief residents of those programs. Only 11 of the 21 programs had an integrated abortion curriculum. Of the remaining ten programs, two were inactive, one offered no abortion training, three allowed

residents to search out their own abortion training, and the remaining four offered training as an elective. These results are not comprehensive, as the study only resulted in a 70 percent response rate.(36)

Seven years earlier, a similar study was conducted where residency directors were questioned and asked to give a questionnaire to the first alphabetical chief resident in the program. The response rate for this survey was lower than the later study at 58 percent. More than half of both chief residents and residency directors responding reported no oral teaching of abortion, including grand rounds, lectures, or other didactic sessions devoted to the subject.(29)

A study published one year earlier, surveying family medicine residency directors and senior residents, found that 12 percent of programs offered abortion training. Directors of programs that included training estimated that just under half of all residents participated; residents estimated a slightly lower number. By far a much higher proportion of Western programs offered training in comparison to their Northeastern, Midwestern, and Southern counterparts. Almost half of senior residents at programs without abortion training were not aware that residents in other programs were learning abortion skills. One quarter of residents in these programs expressed interest in obtaining this training. However many directors commented that training was not included because residents did not want it.(24)

It is not clear whether the non-respondents to these studies would be more or less likely to be from programs offering abortion training. One might

argue that programs offering training would be more interested in replying as they are interested in the subject in general. The authors of one study assert that the respondents are those more likely to feel strongly in either direction on the topic.(29)

In terms of clinical training in abortion, the 1995 survey showed that only three percent of chief residents, three months from program completion, had managed ten or more cases of first trimester elective surgical abortion. Eighty five percent of respondents had had no clinical experience in vacuum aspiration abortion, and 74 percent reported no training in the procedure. The responses for lack of incomplete abortion management were lower but still high, with 45 percent reporting no training in vacuum aspiration for incomplete miscarriage and 53 percent no clinical exposure. This was particularly true for residents training in the Southern United States when compared to those in the West and Northeast.

Residency programs described available abortion training for residents. Twenty-nine percent of programs responding reported that abortion training was either available or optional, but 67 percent of chief residents from these programs had no training in the procedure. Two-thirds of programs affiliated with a medical school did not offer abortion training at all.

When asked their preferences on the subject, 65 percent of responding chief residents replied they certainly would not provide first trimester abortions in their future practices. Only five percent said they certainly or probably would do so. Residents were divided on whether it was appropriate for family

medicine residency programs to provide abortion training, but were much more likely to feel that it was appropriate if they were in a program that provided abortion training. Almost 40 percent of respondents felt abortion training should not be included in family medicine residencies at all, while only 11 percent agreed that it should be routine.(29)

Overall, even the most interested residents will have difficulty obtaining training in abortion provision in most family medicine residency programs. Residents choosing to opt out of abortion training do so for the most part based on their religious or moral beliefs. And, as seen in other studies of practicing family physicians, while many residents believe in the importance of the availability and accessibility of abortion care, few expect to provide it themselves.

When the STFM group examined the fill rates of the eleven programs that integrate abortion training compared to all family medicine programs, they discovered that while 49 percent of all family medicine programs fill with seniors graduating from U.S. medical schools, 77 percent of the programs integrating abortion education filled their slots. Although, they explain, there could be confounding variables such as desirable location or increased procedural experience, the authors encourage further research into this arena, as these results point to a demand, on the part of graduating medical students, to train in programs offering abortion education. This is encouraging news for programs interested in expanding their abortion curriculum.(36)



Abortion training in family medicine residency is not required by the American College of Graduate Medical Education (ACGME). This group, made up of representatives from the American Medical Association, the American Board of Medical Specialties, the American Hospital Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies, accredits the 7,400 residency programs in the country.(37) It is the responsibility of each individual residency program in family medicine to develop a list of required procedures in which residents must show competence before graduation from the program. “This list must be based on the anticipated practice needs of all family medicine residents. In creating this list, the faculty should consider the current practices of program graduates, national data regarding procedural care in family medicine, and the needs of the community to be served.”(38) Although abortion training is recommended by the ACGME, about three quarters of family medicine programs do not include it in their curricula.(15) Depending on where family medicine doctors practice, however, abortion provision may be necessary in order to fulfill the responsibilities of the sole healthcare provider in an underserved location.

Dilation and curettage for incomplete abortion is included as a core skill required of the family medicine resident. Additionally, the program requirements suggest “voluntary interruption of pregnancy up to ten weeks gestation” for “FP residents planning [on] practicing where gyn care is not available.”(39) Residents are also expected to have knowledge of “abortion issues and counseling,” as well as “emotional impact of abortion.”(40)

In addressing reproductive decisions, the AAFP expects the resident to provide a pregnant patient with “safe, legal abortion services should she choose not to continue the pregnancy; or [i]dentify resources where such information can be obtained.”(41) From the data above, however, few residency programs are making this a possibility for their residents, as a minority offers any kind of training in abortion care.

In the mid 1990s there was an attempt to pass a resolution within the AAFP stating that abortion care is within the scope of practice of family medicine. Supporters of this initiative hoped it would lead to insurance reimbursement for the procedure and increase the chances of abortion becoming a curriculum requirement for residency training. But the AAFP is a conservative organization, with much of its membership grandfathered into family medicine as general practitioners from the time before family medicine became its own specialty. Many members don't support abortion and the congress of delegates did not want to create controversy within the organization.(42) As will become evident in the discussion of abortion training in obstetrics and gynecology residency programs, making abortion training a requirement of residency education does not necessarily ensure nationwide training in all programs.

One barrier to education is that most abortions take place outside the hospital setting, so programs must find community sites to include in their training.(15) Further, programs affiliated with religious institutions, as many

are, have difficulty offering training, for both logistical and regulative reasons.(24)

There are models, however, of family medicine programs incorporating training into their required curricula. Much of this is due to the generosity of an anonymous foundation that funds these programs.(42) One recently published article sets an example of how to incorporate this training into programs, laying the groundwork so other programs can follow suit, learning from those who have gone before them.(43) The news is promising: in 2005, at least three programs added abortion training to their curricula, and possibly four plan to in the coming year.(42)

## Abortion Teaching in Medical School

*Future physicians' attitudes may thus dramatically affect patients' access to abortion.(42)*

When the “Bottom Feeder” pamphlet mentioned in the introduction of this paper was distributed to half of all U.S. medical students in 1993, a group from a local Planned Parenthood office responded by preparing a mailing to distribute to all medical students with facts about the falling number of abortion providers and the unequal distribution of providers resulting in lack of access for many women throughout the country. The mailing also mentioned information about how to become a member of Medical Students for Choice (MSFC), a group of pro-choice medical students that had formed in reaction to the cartoon flier. Within a year, the membership of that student group had increased five fold. In their article on the need to educate medical students about the abortion provider shortage, Steve Heilig and Therese S. Wilson admit they cannot assert that the pamphlet resulted in the increased membership. However, they argue, if such a pamphlet were to be distributed every four years in an attempt to reach every American medical student, physicians would be aware of the situation and, perhaps, more inclined to train in abortion instead of simply supporting it.(1)

Unfortunately, no such pamphlet is being distributed. In fact, a minority of medical students are exposed to abortion in their lectures or clinical rotations. As residents, physicians in training, they have even fewer opportunities to learn

about this common procedure. Although recent doctors in training have not received a nationwide message maligning abortion provision as they did in 1993, the legacy of that cartoon pamphlet lives on.

In 1996, a study of first and second year medical students at the University of Washington found that 58 percent agreed first-trimester abortion and 26 percent agreed second-trimester abortion should be accessible to women in almost all situations (the other options were: accessible with limitation, should not be accessible, and uncertain). Regarding medication abortion, 41 percent felt it should be accessible most of the time.(44) In a similar study conducted in 2002 at that same school, almost three quarters of second year medical students agreed that “elective abortion should be legal and accessible under any circumstance.” One third felt more comfortable with medical abortion than surgical abortion. Two thirds believed programs addressing women’s health should include abortion training.(45)

Of the second year students in the 2002 study, one third planned to incorporate medical abortion into their future practices, and one fifth planned to incorporate surgical abortion. Only five percent of all respondents would not be willing to refer patients to other clinicians for an abortion.(45) Their 1996 counterparts, with the exclusion of those who believed reproductive healthcare lay outside the scope of their future practices, responded similarly, with 27 percent planning to provide first trimester and 29 percent planning to provide medication abortion under most circumstances. The responses to second trimester abortion were much lower, with only seven percent intending to

provide. One quarter replied they would not be willing to provide first trimester abortion under any circumstance; almost one third replied similarly in the case of second trimester abortion.(44)

Although this is a very small sample and a potentially skewed pool of medical students, the results reveal that to at least one medical student population, abortion is a relevant subject to address in medical education. The authors of the earlier study admit that Washington University might attract a disproportionate number of students interested in abortion care as their residency programs in Obstetrics and Gynecology as well as Family Medicine are known to offer abortion training. Additionally, the program specializes in rural and family medicine.

A study in a different setting, the University of Illinois College Of Medicine, supports the theory that the Washington University students were a skewed sample. Second-year medical students in Chicago were questioned about their views on abortion training in 1996. Fourteen percent said they would never perform or refer for abortion. The authors of this study found that students with increased sexual experience were more likely to display liberal thinking on abortion issues. They cited previous research that showed that student's thinking on abortion becomes more liberal with their medical education.(46) The University of Washington study had similar findings, with female and older students, particularly those over 30 years, more likely to be interested in providing abortion in their future practices.(44)

When asked why they would not provide abortion services, the Illinois medical students gave the following reasons: one third claimed it would be outside the scope of their practices or was against their personal values, one quarter stated it was against their religious beliefs, four percent did not think it would be covered in their training, and that same number stated fear of physical violence against them or their families as an obstacle. Less than one percent feared being ostracized or discriminated against by colleagues.(45) These results are useful, again, within the limited population, in concluding that violence in clinics and social pressure, contrary to popular opinion, are not affecting this population's decision about abortion provision.

Of the 1996 cohort of Washington medical students who supported wide access to first trimester abortion, 60 percent intended to provide it themselves. For second trimester abortion, this number was 40 percent.(44)

In terms of seeking training in residency, when asked, almost 70 percent of respondents said they would attend a program with mandatory abortion training. Half would take electives in abortion, and just over one quarter would specifically seek a training program offering abortion teaching.(45)

Teaching objectives for medical student education, including abortion care, are outlined in the Association of Professors of Gynecology and Obstetrics (APGO) Women's Health Curriculum Recommendations.(47) Additionally, guidelines for competencies in undergraduate medical education regarding Women's Health were developed at a conference in 2000 attended by members of many interested organizations, and presided over by APGO. Included are

knowledge of medical and surgical abortion, complications of the procedure, and options counseling for pregnancy.(48)

A study conducted in 2003-2004 surveyed Obstetrics and Gynecology Clerkship Directors at all 126 accredited United States Medical Schools on abortion training offered in the pre-clinical and clinical years of medical school. The response rate was 62 percent, with extensive follow-up of non-respondents.(47) It can be speculated that the majority of non-respondents would be directors of programs that offer very little or no abortion teaching. However, it is also possible that directors did not respond for other reasons besides the content of the survey. Abortion training covered by other specialties such as Family Medicine was not reported in this survey.

The authors found that almost half of programs stated they held no formal training in abortion during the first two years of medical school. At least one quarter of the time, abortion was mentioned, or the subject of a lecture given to first or second year students. The same number of respondents did not know the abortion related content of teaching in the first two years.(47) This is not surprising, as often education during the first two years is quite distinct and run by different faculty from the clinical years. However, this does elucidate a gap in education continuity. If programs are interested in incorporating abortion training, or any piece of medical education into their curricula, it would help to have well established lines of communication between the pre-clinical and clinical components of education.



Regarding the required third year clerkship in Obstetrics and Gynecology, 45 percent of directors stated that clinical experience with abortion was included and about one third of the time abortion was mentioned or the subject of a lecture. Of the 35 programs that included clinical exposure to abortion, eight required students to ask specifically for the experience while the remaining 27 had an integrated experience that the students were alerted to beforehand. Among the integrated programs, ten reported that few students participated, three stated only half the students participated, and eight claimed that many students took part in the experience.<sup>(47)</sup> Although the authors do not address the fine point of these results, one would conclude that the majority of students opt out of the clinical experience in abortion during the third year clerkship at 27 of the 35 programs reporting. In other words, even for the programs that include abortion training as part of the clinical experience of medical students, most students choose not to participate at all.

This raises the question of why, if so many students express interest in abortion provision and abortion training, they are not taking advantage of training opportunities. Once again, the possibility of skewed sampling in the student opinion studies cannot be ignored. It is a much more accurate gauge of student interest to examine how many choose to participate than rely on studies of two medical student populations. It is also possible that there are deterrents to student's attendance in the elective abortion experiences.

For responding programs, a clinical experience was either a half day or one week of the gynecology clerkship spent in a facility where abortions were

performed. Students were more likely to participate if there was a faculty member who performed abortions and advertised the experience. Respondents also noted that abortion was covered in the pre-clinical ethics course.(47) For many medical students, an ethics discussion is the only exposure to abortion they receive during their pre-clinical education.

Some feel that since ethics training is the one place in medical school where abortion is addressed, it could do more to address the issue. Sarah Blyth, a medical student and MSFC member, writes that medical curricula encourage students to examine their personal feelings about many ethical issues such as euthanasia, domestic violence, and drug abuse. Students are then taught to set aside their own perspectives in order to provide care to their future patients.(49) But when abortion is included in these ethics discussions, even in cases of medical necessity, students are not asked to think in these same terms.

Just under one fifth of programs did not address abortion at all during the third year clerkship or in the pre-clinical year. Half of responding programs offered a reproductive health elective in the fourth year but reported a participation rate of ten percent or less. While these electives are useful for students already interested in abortion care, they do little to expose others.

Medical professionals, at many stages of their training, have expressed greater confidence in skills learned while in a clinical, rather than lecture, setting. Additionally, students prove to be more interested in women's access to abortion once they have been exposed to it during their education.(47)

Among first and second year medical students at the University of Washington Medical School, the majority declared their intentions to practice family medicine and provide abortions.(44) What happens to these medical students once they complete their four years of training? Do they lack exposure to abortion training? Do they have negative experiences with the exposure they have? Does the interest in becoming an abortion provider wane during residency, when they learn they must use elective time to learn the skills? Or are they discouraged by their teachers during residency who either don't provide abortions or do but have negative things to say about their work?

Apart from the clinical rotations, there are many opportunities, in addition to an ethics class, to address issues relating to abortion. Pharmacology classes could discuss the use of Methotrexate for pregnancy termination in addition to the treatment of cancer and autoimmune disease. Epidemiology classes could address the number of women undergoing this procedure, and look at the cost effectiveness of insurance companies not covering contraception or abortions, but paying for Viagra and the care of fetuses born with severe anomalies. Some MSFC chapters take matters into their own hands and organize 'Sex Weeks' and 'Reproductive Choice Fairs' to introduce their student bodies to pertinent topics.(50)

Among options for students interested in abortion training outside the standard curriculum is a summer internship offered by MSFC, for the summer between first and second years of medical school.(51) Additionally, the American Medical Women's Association (AMWA) places interested students in

fourth year women's health electives that can include reproductive health care and abortion training.(29) MSFC also offers \$1,000 stipends to students taking a Reproductive Health Elective in their third or fourth year.

A minority of teachers are doing more to educate students about abortion. In addition to teaching the procedural aspects of pregnancy termination, Felicia H. Stewart and Philip D. Darney are "Teaching Why as Well as How," as they explain in their article of this title. The authors, both of whom are on the faculty of University of California, San Francisco's Department of Obstetrics, Gynecology and Reproductive Sciences, explain that many students who may have access to training in abortion learn the technical pieces of the procedure but, as most counseling and options discussion is conducted by lay staff, do not participate in the crucial component of learning why a woman is in this unfortunate situation. They assert, further, that learning why women choose abortion might be the critical piece students and residents are missing in deciding not to provide abortions in their future practices.(4)

This sentiment is echoed in reference to residency training, where some young doctors choose abortion electives for increased training in ultrasound or options counseling. The increased exposure to abortion, however, becomes career-altering, as they realize "that women who get abortions are not monsters, and that Planned Parenthood is not a torture chamber."(42) At any point along the educational trajectory, physicians are more likely to realize the normalcy and necessity of this procedure. As one of my medical school classmates understood, after assisting during a D & E on our ob/gyn clerkship in order to

“see what the big fuss is all about.” Afterwards, he told me: “It wasn’t such a big deal.”

## Abortion Training in Obstetrics and Gynecology Residency

*[W]omen spend most of their reproductive years seeking ways to control their fertility and...gynecologists have an essential role in helping them accomplish this safely and effectively.(52)*

Recently in a conversation with physicians who have been practicing in the Boston area for thirty years, I spoke about the problem of abortion provision in this country. “You mean not all obstetricians are taught to do them?” I was asked. There is an assumption that physicians who are dedicating their practice to women’s reproductive health are all trained in abortion care. This is not the case. In fact, none of the residents teaching me on my ob/gyn clerkship was interested in doing abortions. “I just wouldn’t feel good about myself,” one explained.

In 1978, in order for a graduating obstetrics and gynecology resident to become board certified, he or she had to pass written and oral exams. Additionally required were written testaments to his or her experience in three categories, one of which was abortion.(26)

In 1995, the ACGME clarified their requirements for obstetrics and gynecology residency programs.(24) The new requirements mandated that abortion training be made available to interested residents. Programs and individuals with objections to the procedure were not required to participate.(53) This exemption was nothing new. In the early days of legal abortion, in the mid 1970’s, residency programs were expected to excuse

students with “moral or religious objections” from participating in abortion training.(26) Abortion rights advocates theorized that training all ob/gyn residents in the procedure would decrease stigmatization and violence against providers.(53)

Shortly after this new directive went into effect, a study of residency programs found that just under half were including first trimester abortion training, with one third offering the training as an elective. The numbers are slightly lower for second trimester training. While one quarter of all responding programs reported that all residents trained in abortion provision, 40 percent reported less than half of their residents received training, and 14 percent reported no residents had trained at all. An interesting finding was that the majority of abortion training in residency takes place in operating rooms, not outpatient facilities, where most procedures occur.(54) Although residents are gaining exposure, depending on their training location, many are seeing abortion in the hospital setting, where five percent of abortions took place in 2000.(5) As program directors in obstetrics and gynecology have been found to over-report abortion training when their responses were validated through interviews with chief residents in the program, these numbers may be inflated.(55)

But, as always, data on this topic are also unreliable due to low response rates.(15) Interestingly, in 1985, more than one quarter of obstetrics and gynecology residency programs were requiring abortion training. This number is twice that reported after the passage of the ACGME requirements.(35)

A study of graduates from five obstetrics and gynecology residency programs surveyed practicing physicians on their abortion training and current provision. The study found that 83 percent of respondents had participated in some sort of abortion training during residency, with one third performing more than 50 first-trimester procedures. Nearly half of respondents had performed a first-trimester abortion in the year previous to the survey administration, with the majority performing ten or fewer procedures per month.

The study of residency graduates found that graduates of programs with extensive and integrated abortion training were more likely to include abortion provision in their future practices. The relationship is linear, in that “the more integrated and extensive the training, the more likely the graduate is to provide abortions.”(56) The authors admit that they did not attempt to discern whether abortion-providing graduates had entered their training interested in providing or had become interested during their training. They recommend, however, based on their findings, that, in order to train future abortion providers, “programs should include routine, hospital-based training in both first- and second-trimester procedures with sufficient numbers to ensure competence.”(56)

In light of this, the results of a recent study conducted on third-year residents at University of California, San Francisco’s obstetrics and gynecology program, a program known for its extensive abortion training and robust faculty attention to this topic in research and teaching, are not surprising. All residents participated in abortion training and rated their experience as superior to any



other training experience during residency in terms of satisfaction, educational value, and learning experience.(57) Although it is valuable to know that such training can be so successful, this is not always the case.

In her study of one obstetrics and gynecology department's struggle with abortion training, anthropologist Ellen Lazarus identifies many problems with having a procedure that residents can opt out of participation. For example, those who chose to participate "felt punished and abused and often resentful toward residents who refused to perform abortions."(35) The program director was uninterested in Lazarus' survey findings that showed resident dissatisfaction, fearing bad publicity for the hospital if the issue was aired.(35)

When problems arose because too few residents were willing to perform second-trimester procedures, the solution was to pay residents to do them and, additionally, send them to a conference that was considered a "second vacation."(35) The program's solution to the problem of providing women the care they needed was to bribe residents into performing jobs no one wanted to do.

As mentioned above, suction curettage is the most popular method of early abortion. It is the same procedure used for emptying the uterus of its contents after an incomplete miscarriage. Dilation and curettage, the procedure used for second trimester terminations, is also a therapeutic procedure performed on post-menopausal women with excessive or irregular uterine bleeding. Because residents are not training in abortion procedures, either due to lack of access to training or because they are choosing not to participate,

many are not learning the skills necessary to manage patients after miscarriages. One attending physician from an obstetrics and gynecology residency program in the Midwest was appalled by the lack of skill exhibited by the chief residents who were asking first year level questions about the procedure.(35)

Opponents to the ACGME requirements have argued that residents do learn the techniques they need to know through post-miscarriage care, including uterine evacuation. Further, they say some programs teach residents terminations only when the fetus has anomalies incompatible with life or the mother's life is endangered.(53)

For some perspective on residency training, it helps to look at the survey of obstetrics and gynecology residency programs conducted by the Alan Guttmacher Institute in 1976, just three years after legalization of abortion. The authors gathered information from respondents who made up 60 percent of all program directors of accredited ob/gyn residency training programs. They evaluated the responding institutions by location and type of hospital and concluded they comprised a fairly representative sample of obstetrics and gynecology programs to apply their findings to the entire country.

One quarter of all institutions required first-trimester abortion training and nearly that many required second-trimester training as well. Whereas about eight percent of programs did not offer any training in first-trimester abortion, twice that number did not offer second-trimester training. Not surprisingly, the breakdown of Catholic versus non-Catholic versus public hospitals was distinct, with the majority of Catholic institutions not offering any training. The private

non-Catholic institutions in general offered more training than the average of all three hospital types. Similar to abortion provider geographical trends previously discussed, northeastern institutions were much more likely to require training than were programs in the south. Based on responses to questions about participation, the authors conclude that about 40 percent of residents were not being trained at all.(26)

The most recent study on the topic of trainee opinion examined Philadelphia area obstetrics and gynecology residents' attitudes toward participation in abortion procedures based on gestational age and reason for the termination. The authors found that individual's opinion on abortion dictated their willingness to participate more than factors such as gender, age, parenthood, or training availability at a specific residency program. Surprisingly, some self-identified pro-choice respondents were unwilling to participate in procedures that some pro-life residents would attend.(58) These findings contradict those of researchers who asked second-year medical students their opinions about abortion. They cite previous work that has shown that "a physician's personal beliefs about abortion influence their practices."(46) This is helpful in realizing that physicians do not enter medical school as pre-ordained abortion or non-abortion providers. The more exposure they have to the complex issues surrounding reproductive healthcare during their training, the more likely they will be to form their own opinions and make practice decisions based on them.

There are many deterrents to creating abortion training programs, such as religious hospital affiliations that prohibit the procedure, or low volume abortion provision leading to inadequate exposure for residents. As one abortion education advocate articulated, it is unacceptable “that the Catholic Church is allowed to determine a curriculum when this is not even a Catholic government.”(42) She cited as an example a formerly Catholic hospital that had been bought out by a secular organization with the stipulation that no abortions could ever occur in any buildings formerly owned by the Church.(42)

As with training in family medicine residencies, a further obstacle to training is that the vast majority of procedures take place in the outpatient setting, and few residency programs have access to those facilities. But there are examples of residency programs partnering with abortion service providers in order to ensure adequate exposure for their residents,(59, 60) showing that, despite the odds, it can be done.

## Regulatory Issues

*[T]here will be an even greater shift from decisions made by women and their doctors to decisions made by state legislatures as they attempt to regulate abortion.(35)*

In order to provide abortions within the law, doctors must do more than seek out and find time for the training. Specific state regulations regarding abortion facilities, including square footage and hallway width requirements, provide further obstacles, as 95 percent of abortions are performed in clinics or physician's offices.(5) The restrictions increase the cost of the procedure for providers, requiring more staff and adding paperwork.(61) These so called Targeted Regulations of Abortion Providers, TRAP laws,\* apply to providers of medical abortion as well, even though that "procedure" does not even take place on site.(16) The TRAP laws do not apply to clinics already in place before their passage, further dissuading anyone from opening a new practice.(61) States also differ in their notification and waiting period requirements surrounding abortion and the provider must become familiar with and adhere to local laws.(16)

Although family medicine physicians are ideal abortion providers for many reasons, logistical impediments to incorporating a small number of terminations into a diverse primary care practice need to be addressed.

Malpractice insurance premiums, for example, soar when providers add

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\* As described on the website of the National Abortion Federation (NAF). The source for this nomenclature is not clear, but is presumed to be attributable to a pro-choice group such as NAF. [http://www.prochoice.org/policy/states/trap\\_laws.html](http://www.prochoice.org/policy/states/trap_laws.html), accessed April 29, 2006.

abortion to their procedures lists.(16) Additionally, some insurance companies refuse reimbursement of family doctors for abortion provision, despite their qualifications and training. In the mid 1990s, a small group of family physicians hoped to change this by proposing a resolution to the American Academy of Family Physicians, stating that abortion was within their scope of practice. Instead of that resolution, however, the issue was incorporated into the problems providers encountered with reimbursements for other procedures, like colposcopy and palliative care. The resolution that finally passed was a general one stating that family physicians should be reimbursed for anything they are trained to perform, without ever mentioning abortion.(42)

Abortion training in residency, the most effective way to create abortion providers, has faced many obstacles. When the National Abortion Federation (NAF), a professional group of abortion providers, and the Council on Resident Education in Obstetrics and Gynecology (CREOG) co-hosted a conference on the lack of training of future abortion providers, one of the results was the 1995 mandate, five years later, for abortion training for obstetrics and gynecology residency accreditation.(51) The ACGME executive director stressed that the ruling would not force any institutions to perform abortions, only to ensure training for interested residents.(62)

Despite his assurances, the new requirements prompted outcry from several groups and elected officials. One such organization, Catholic Hospitals of America (CHA), claimed the rules did not exempt religious hospitals where abortion training is inconsistent with church teaching. CHA also warned it

would “examine all options to challenge the ACGME’s new mandate.” The ACGME met with CHA and soon revised the ruling to include exemptions for opposing institutions.(62)

Michigan Representative Peter Hoekstra accused the ACGME of “pushing a political agenda” in passing the ruling in the first place.(37) In response to the opposition, Congress passed a resolution protecting non-compliant programs from loss of federal funds.(51) Shortly thereafter, the Coats Amendment to the Omnibus Consolidated Rescissions and Appropriations Act of 1996 (Pub L 104-134) was passed preventing obstetrics and gynecology residency programs from losing their accreditation if they do not offer abortion training to their residents.(15)

Some considered these actions “an ominous precedent for the future of professional education in the USA.”(63) ““This is the first time the government has involved itself in the setting of accreditation standards in medicine,”” said John Gienapp, PhD, executive director of the ACGME.(64) Officials, mostly Democrats, also expressed concern. Among them was Massachusetts Senator Edward Kennedy who asserted that “[p]assing a law that substitutes Congressional and political opinion for medical decision-making is wrong.”(63) Ohio Representative Thomas C. Sawyer agreed, predicting Congress was “setting the stage for even broader intrusions.”(37) Congress’ passage in 2003 of the so-called Partial Birth Abortion Ban, placing restrictions on certain abortion procedures, and transferring abortion decision-making power from the

medical into the political realm (51) is one strong example of his predictions coming true.

In their provocative editorial shortly after the 1996 amendments passed, *The Lancet* labels these bills “unnecessary and deceptive.” The bills, the editors explain, would allow a training program to refuse to train residents in abortion for reasons other than religious or ethical. They argue that programs might make the case for dropping abortion training because it is not cost effective and a nuisance.(63) Where else in medical training are these criteria applied to the argument for neglecting to teach doctors necessary techniques?

Making it even more difficult for residency programs to comply with abortion training requirements, several state laws ban elective abortion procedures in public institutions, where medical education often takes place. To counteract this, some states, like California and New York, are promoting abortion training through legislation. Both states mandate abortion teaching in all public hospitals, with allowance for those who object to decline.(15)

Some pro-choice organizations, aware of these barriers, are working to make training more available for would-be providers. MSFC, as mentioned above, and Physicians for Reproductive Choice and Health (PRCH) were both born in response to opposition to abortion.(16) PRCH members include abortion providers as well as abortion-supportive physicians committed to improving access to and reputation of abortion provision.(51) Along with other organizations like NARAL Pro-Choice America, NAF, and Planned Parenthood Federation of America, these groups work to encourage education and training



in abortion and other reproductive healthcare services. NAF and Planned Parenthood are even extending their educational efforts to include magazine advertisements and internet postings aimed at the general public.(16, 51) NAF is accredited by the Accreditation Council for Continuing Medical Education (ACCME) and is the only organization that conducts accredited abortion training for continuing medical education.(65)

In addition to organizations dedicated to the cause, fellowships and training programs focus on education and providing access to training. The Ryan Residency Training Program (RRTP), a privately funded organization founded in 1999, works toward advancing abortion training in programs throughout the country. RRTP members have been involved with drafting the California legislation mandating abortion training in public hospitals and implementing a similar law in New York institutions. They also help create formal abortion rotations in interested obstetrics and gynecology programs.(15) As mentioned in the discussion of family medicine resident training, a private foundation funds the establishment of similar programs for family medicine residents.(42)

The American Medical Women's Association (AMWA) founded the Reproductive Health Initiative to ensure that contraceptive and abortion education is included in medical school curricula.(52) AMWA also began offering clinical electives in reproductive health to interested students in order to supplement medical student education in this arena.(63, 64)

Planned Parenthood of New York, in response to difficulty finding physicians to staff their clinics, implemented a program to teach residents themselves at their clinic sites in 1993.(60) Although this helps solve the training problem, it exemplifies the marginalization of abortion by the medical community. “I’m grateful they’re doing it, but I think it’s outrageous that Planned Parenthood has to educate medical students and residents about this, instead of medical schools,” commented the associate education director at one of New York’s medical schools.(66)

Some groups are aiming their efforts at family physicians, realizing the important role they could play in abortion provision. One such group, the Access Project, delivers information and training to family physicians on medical abortion.(16) The 13-year-old Fellowship in Family Planning creates opportunities for interested physicians to train and conduct research in abortion and other contraceptive issues.(16, 52)

The Food and Drug Administration’s approval in 2000 of the use of Mifepristone, also known as RU486, was predicted by some to be a turning point for abortion provision in this country. Many saw it as an opportunity to make abortion much more accessible to women everywhere. Without the need for a surgically trained physician with operating room access, any doctor could help her patient obtain a private pregnancy termination. But it has failed to become a solution to the problem of access. Although many more outpatient settings are offering it to their patients, there are still obstacles to its provision,

just as there are obstacles to providing surgical abortion in the primary care setting.

Medication abortion does open the way, however, to non-physician abortion providers, also called advanced practice clinicians. Included in this category are nurse-midwives, physician assistants and nurse practitioners, all of whom would help eliminate the provider shortage if they were to offer abortions to their patients.(45) The Abortion Access Project in Boston has already trained 30 such practitioners who are providing medical abortions in the northeast.(16)

In spite of evidence supporting the safety of these providers performing the procedure, forty-four states have laws prohibiting advanced practice clinicians from performing abortions.(67) These laws exist mostly from their post *Roe v. Wade* position of protecting women from untrained abortion providers, rather than limiting the scope of advanced practice clinicians.(45) However, with the increase in these providers as the only healthcare for many rural areas, these laws now do act to limit women's access to proven safe procedures.

## Perceptions of the Abortion Provider

*[T]he medical establishment has yet to welcome in abortion providers and gynecologists who are committed to women's choices.(66)*

It is easy to blame family medicine and obstetrics and gynecology residents for not training in or planning to provide abortion services. But this issue is the responsibility of the entire medical community. All medical care providers are at fault when this procedure is not equally available to women everywhere. “The medical community seems to have collectively chosen to ignore the medical imperative of safe, legal access to abortion,” writes a medical student in an article outlining the lack of abortion access.(49)

We are taught in medical school about moral obligation to our patients. One young physician cited the Hippocratic Oath as her reason for becoming an abortion provider: “We--all of us--sign the Hippocratic Oath, which means that we’re supposed to take care of people who need us.”(22) Physicians are not fulfilling their moral obligation to the patient community of women which needs these services. Blaming the resident for not seeking out training is too simplistic. Instead, we must look to the larger climate of medical attitudes towards abortion care: the “not in my backyard” mentality evident when the majority of medical students claim they support a woman’s right to available and accessible abortion in all circumstances but only one third of students intend to train in abortion provision.(16, 22)

Many providers admit to feeling marginalized by other physicians, who see them as doing the dirty work of the profession, and ““they’re more than happy to let somebody else do it.””(22) This attitude is not new, as seen in comments from the president of a New York clinic offering abortions in 1995. She perceived others considering her a “pariah” for her work.(66) Many providers speak of the isolation they feel in doing this work.(61, 68)

In 2002, NAF was refused access to an Emergency Medicine conference with the claim that the information they had would not be relevant.(16) Although emergency physicians do not traditionally perform abortions, they see patients who present with complications from abortions, as well as those who are intending to terminate a pregnancy. So although they are not direct providers, their practice scope requires knowledge of the procedures women obtain.(19, 65)

Other examples of marginalization include omission of any mention of abortion in textbooks on women’s health and the difficulty researchers confront in publishing studies on abortion.(16) This is not an obscure procedure that physicians are unlikely to see unless they are specialists. Every physician taking care of women will have patients whose lives are affected, whether through direct experience, or unavailable access. The roots of this marginalization and physicians’ theoretical support but actual avoidance reflect the ambivalent history of abortion in this country.

On the larger scale, the example of Henry Foster discourages physicians with public sector goals from addressing this politically volatile procedure.

Foster's nomination as Surgeon General for the Public Health Services during the Clinton administration is believed to have been defeated by Congress because of his career-long abortion provision.(35)

Regarding comprehensive abortion teaching to medical students, UCSF professors Stewart and Darney explain that an additional reason why abortion provision has the connotation of 'dirty work' physicians want someone else to do may be the public health perspective that advocates for legal abortion. Instead of using examples of poor health consequences for women without access to safe abortions, they argue, why not bring specific women's perspectives to the table to show how abortion affects individual patients, not just general populations.(4) The meager abortion training that is available to U.S. medical students focuses on the technical aspects of the procedure. If students were exposed to each patient and her situation, Stewart and Darney propose, many would be more likely to decide to become providers.

In a survey of third-year medical students participating in the obstetrics and gynecology clerkship, findings support this thinking. The authors offered a half day experience at a local abortion clinic as an optional part of the clerkship. They questioned all students, whether they chose to participate or not. They found that, contrary to previous findings, students who participated were not more likely to be older, female, or those with more sexual experience. Instead, equally diverse groups participated and chose not to, differing only in their belief as to the importance of accessibility for all women to this service. They also learned that the students who participated took more than the procedural

aspects of abortion care with them. The students who met women terminating their pregnancies learned about what life situations brought those patients into clinic. They were then increasingly likely to feel more strongly about abortion access than their peers without the experience.(48)

It would be helpful for future physicians to hear abortion providers speak about why, despite the obstacles, they continue to deliver this care to their patients. With declining numbers of providers and physicians' reported dissatisfaction with providing abortion care, future physicians might wonder why anyone would choose to perform abortions. What does one gain from a procedure requiring extra training time, with poor reimbursement, and potential personal danger?

Older providers cite seeing the results of botched illegal abortions in the hospital beds of gynecology wards throughout the country as the motivation to help women obtain a legal and safe procedure after 1973.(22, 34) This might explain why today's physicians don't feel the responsibility to perform abortions: they never saw the results of women's desperation to control their reproductive lives, at all costs.

Many providers report a personal satisfaction with the work, although for some, there is no pleasure, only duty that drives them.(22, 69) Others derive gratification from knowing they are helping women at a desperate time in their lives.(22) In her book of interviews of abortion providers, sociologist Carol Joffe highlights some of the reasons physicians choose this unpopular line of work. One of her subjects explains the draw: "There is nothing else I do in my

medical practice where people look me in the eye, in quite the same way, and say 'thank you.' I feel I am empowering women.'"(4)



Conclusion: Ethics and Morality

*Like the choice to provide medical care on a battlefield or in times of civil strife, the choice to provide abortions is framed by historical context and moral debate; abortion has become a political act and an act of conscience.(70)*

Dr. Lazarus examines the decision not to train in abortion provision at a Midwestern obstetrics and gynecology residency program. She sees the residents using the choice as a way to assert autonomy during a period in their lives when they have little power. Although only 10-15 percent of surveyed obstetricians and gynecologists identified themselves as morally opposed to abortion 20 years ago,(35) far fewer than the remaining 85 percent include abortion in their practices.

Lazarus' account also gives plenty of examples of the necessity for ethics teaching during medical school and residency. She describes the treatment of one resident toward a non-English speaking patient pregnant with a fetus with multiple anomalies. Throughout this unfortunate woman's abortion experience, she was mistreated. The resident's refusal to sign the fetus' death certificate, a request by the family for whom this had been a desired baby, displays the young physician's insensitivity to the issues at hand. To make matters worse, a medical student working with this resident observed the entire episode. Lazarus concludes: "medical training must expressly address abortion as both an ethical issue and as a professional issue."(35)

In her account, Lazarus goes beyond recommending increased ethics training. She suggests that residents should not be allowed to opt out of abortion training until a thorough examination into their individual feelings on the issue can be pursued. Like Stewart and Darney, Lazarus supposes that many physicians-in-training choose not to address the complicated matter of abortion provision at all. If given the choice, why wouldn't most people want to avoid a highly politicized matter that they were not required to participate in?

While training in technical skills is important for ensuring future physicians will be prepared to perform more than one million abortions per year, it seems that more is required to guarantee abortion provider access for all American women. A fundamental change in the approach to abortion training is necessary. Lazarus recommends the inclusion of ethics classes throughout medical school and residency to address these issues. Additionally, she suggests an ethics committee composed of multi-disciplinary care team members who would meet to discuss cases and eventually produce a portfolio of cases to present at grand rounds.(35)

In an address at an annual meeting, the president of American College of Obstetricians and Gynecologists (ACOG) admitted to how poor the preparation in ethical decision-making is for most obstetrician/gynecologists. The result, he concluded, is that most physicians “view ethics in terms of personal values.”(35) Instead of applying their sense of justice and beneficence, the basic tenets of ethical thinking, physicians base clinical decisions for their patients on what is important to the physicians themselves. Research has shown

that, in terms of their moral character development, medical students become stunted during their training.(71)

This absence of adequate ethics instruction extends beyond abortion training. Residents express the desire for counseling education as well, noting they get little of this teaching regarding other issues such as fetal demise or stillbirths.(35) This type of training is recommended by the AAFP “regarding all options available to pregnant women,”(41) but is rarely provided.

Many residents opt out of abortion training, it appears, not because they are morally opposed to the procedure, but because they feel no moral obligation to perform it.(23, 35) AAFP policy supports the option for residents to choose not to perform any procedure “which violates his/her good judgment or personally held moral principles. In these circumstances, the physician may withdraw from the case so long as the withdrawal is consistent with good medical practice.”(41) This exemption is necessary, but should not exist without the occasion for residents to explore what those “personally held moral principles” are. The authors of a study of abortion provision by doctors in rural Idaho found that younger providers were more likely to cite personal moral objection to the procedure as a reason for not performing abortions than were their older peers.(33)

The chief resident whom Lazarus interviews explains how most of the residents frame their thinking when treating a woman interested in an abortion: “First it is themselves, second the fetus, and third the woman.”(35) Although many think that abortion is rejected by most religions, in fact only the most

vocal, the Roman Catholic Church and some fundamentalist Christian sects, believe it is almost always wrong. Many other religious groups see the mother's rights as equally important as the fetus', and conclude that sometimes the decision to have an abortion can be a morally sound one.(4)

Throughout medical training there is a dearth of exploration into the complex ethical and moral issues of providing medical care. The American Academy of Family Physicians (AAFP), in the Recommended Curriculum Guidelines for Family Practice Residents addressing Medical Ethics, suggests "The resident should develop attitudes that encompass...A willingness to embrace the ethical dilemmas presented by his or her patients, to discuss options with the patient and family, when appropriate, and to work toward solutions that are mutually acceptable."(72) Later on in this same document of recommendations, "Human reproductive issues, including contraception and abortion" are listed as some of many "specific patient care scenarios" in which the resident should be able to apply ethical principles as well as governmental laws and regulations.(72)

There are precedents for the inclusion of this topic in medical education. One thing is certain: in order to ensure future generations of American women full control over their reproductive lives, abortion needs to be addressed at all levels of medical training. From pre-clinical medical school lectures and discussions to rotations in residency, the only way doctors will choose to provide this care to women is by early and meaningful exposure to this issue. As much as some people would like to ignore it, the need for abortion in this

country is not going to disappear. Alongside programs teaching abortion should be better counseling and options training, more contraceptive teaching, and a focus on how to address these difficult issues.

Family medicine doctors, with their holistic perspective in caring for individuals in a broader social context, are excellent providers to help women gain control over their reproductive lives. They are not only inherently fit for this job, by their unique approach to patient health, but they are also geographically ideal for this task as well. ““Abortions are a legal, medical procedure, and the safety of the patient is our paramount concern,”” said the obstetrics and gynecology department chair at one medical institution.(37)

One hundred years ago, abortion in the United States was criminal but commonplace. Today, it is legal but growing increasingly inaccessible. Without trained abortion providers, women have no choice. The health and safety of American women depends on increased consideration of this topic throughout all of medical education.

*Unless ethical factors, including altruism, are incorporated into medical training, medicine, despite its advanced technology, will be doing a less than adequate job.(35)*

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