Nearly half of all pregnancies in the United States are unintended and approximately half of those are electively terminated. In 2000, approximately 1.31 million abortions were performed in the United States, but access to abortion services has decreased during the last 14 years. In 2000, 87% of US counties were found to have no abortion services and 99% of all facilities that perform more than 400 terminations per year were located in metropolitan areas. The uneven availability of abortion services influences the distance that women must travel to obtain an abortion, the cost, and the timing of termination, thereby creating barriers to access. This decrease in access has largely been attributed to a decrease since 1982. Legal restrictions, violence and harassment against clinicians who perform abortion, and the aging of clinicians who provide abortion have all been identified as factors influencing the decreased availability.

The decline in abortion services has also coincided with a decline in routine abortion training in residency programs. The percentage of obstetrics and gynecology residency (OB/GYN) programs that routinely included first-trimester abortion training decreased from 23% in 1985 to 12% in 1991. Second-trimester abortion training was routinely provided in 21% of programs in 1985 but only 7% of programs in 1991. The decision to provide abortions is multifactorial, with personal, moral/religious, experiential, situational, and professional influences. However, studies have shown that training opportunities correlate with future provision of abortion services, comprehensive options counseling, and referrals. Following the decline in routine abortion training in residency programs, medical students and professional organizations began to mobilize for reform. In 1993, in response to the shortage of abortion services and growing anti-choice activity, medical students mobilized to form Medical Students for Choice (MSFC), a grassroots organization with more than 7000 members in the United States and Canada. MSFC’s first organizing effort was to petition the Accreditation Council for Graduate Medical Education (ACGME) to make abortion training a required component of OB/GYN residency programs.

In 1995, responding to both the decline in residency training opportunities and the increasing shortage of abortion services, the ACGME made more explicit the requirement that all OB/GYN residency programs seeking accreditation provide routine abortion training. The ACGME requirements differentiate between spontaneous abortion and induced abortion, mandating that all residents obtain training in the management of spontaneous abortion. With respect to induced abortion, residency programs are required to provide “access to experience” and residency programs and/or individual residents with religious or moral objections are allowed to opt out of induced abortion training. This “access” can be provided as either an elective or a required rotation and, unlike other OB/GYN procedures, the mandate does not require that residents perform induced abortion procedures. The ACGME mandate took effect January 1, 1996. A survey of program directors in 1998 suggested that as many as 46% include routine first trimester abortion training. However, all surveys of training programs have been limited by low response rates, lack of resident input, and the absence of clear distinctions between “routine” and “optional” abortion training. Thus the actual prevalence of abortion training remains unknown.

Enforcement of the ACGME requirement was made more difficult when the US Congress adopted what has been termed the Coats Amendment. The Coats Amendment to the Omnibus Consolidated Rescissions and Appropriations Act of 1996 (Pub L 104-134) states that residency programs will be deemed accredited by the federal government, or any state or local government that receives federal funds, even if programs fail to comply with abortion training accreditation requirements. Thus, a residency program that chooses not to provide abortion training to its students either in its own facilities or through an arrangement with another facility is protected from loss of federal funding. Similarly, state and local governments that receive federal funding must also treat these programs as accredited and cannot refuse them “legal status … financial funding, or other benefits.” In response to constituents’ requests for clarification, the ACGME re-wrote its guidelines to require that residency programs with a moral or religious objection to abortion not impede students from seeking abortion training elsewhere.

The Coats Amendment is not the only legislative initiative to challenge full implementation of the ACGME abortion training requirements. Several states have enacted legislation that prohibits public institutions from providing elective abortion services. Although these residency programs can still be in compliance with the ACGME requirements if they provide access to abortion training at an outside institution, these state initiatives make implementation of the ACGME requirements difficult.

Recent initiatives in New York and California have attempted to increase abortion training opportunities in OB/GYN residency programs and implement the ACGME mandates.
date. In 1998, in response to the nationwide shortage of abortion services, the New York chapter of the National Abortion and Reproductive Rights Action League (NARAL/NY) developed the Residency Training Initiative (RTI). The RTI called for New York City’s public hospitals to move from elective to required routine abortion training for the city’s OB/GYN residents (allowing objecting residents to opt-out of training). The initiative, which requires that all OB/GYN residents in the City’s 11 public hospitals be trained in both medical and surgical abortion, was instituted in 2002.

In August 2002, California enacted a state law (AB-2194) that reiterates the language of the ACGME mandate. AB-2194 requires that abortion training be available at each of California’s 6 public medical schools. Like the New York initiative, individual residents and medical schools with moral or religious objections are permitted to opt out of abortion training. However, the California legislation also states that institutions that decide not to teach abortion procedures must ensure that OB/GYN residents can receive abortion training at other institutions. Although the bill does not establish specific curriculum standards, supporters of AB-2194 hope that the bill with compel the ACGME to “demand stricter compliance with its rules.”

NARAL/NY is now working to expand the Residency Training Initiative in the 8 states that train 50% of the nation’s OB/GYN physicians (personal communication, Cristina Page, April 25, 2003). Yet even in a supportive legislative environment, integration of abortion training into residency education remains a challenge for many institutions. In 2000, less than 7% of abortions were performed in hospitals, thus many hospital-based residency programs must establish formal programs with community-based facilities. In 1999, the privately funded Ryan Residency Training Program (RRTP) was created to provide technical and financial support for residency programs to comply with the ACGME, develop curricula and competency criteria for abortion training, and facilitate collaborative relationships between academic and non-academic institutions (personal communication, Uta Landy, PhD, May 19, 2003). The RRTP has worked with the New York City public hospital system to fully implement the New York City training initiative as well as with law makers in drafting the California legislation. Based at the University of California, San Francisco, the RRTP has supported 15 OB/GYN departments in 6 states to establish formal rotations in abortion and expects the establishment of 7 others in 5 additional states in 2003.

To date, educational and legislative initiatives affecting training in abortion have focused almost exclusively on OB/GYN residency programs. Family physicians are often the only source of health care for millions of rural women and the only providers of affordable health care for many poor women nationwide. Although the Council on Residency Education in Family Practice recommends residency training in both contraception care and pregnancy termination (up to 10 weeks’ gestation), a 1995 study found that the vast majority (71%-88%) of family practice residency programs did not include abortion training. Increasing the number of family physicians who perform abortions has the potential to greatly improve access to this service and address some of the current geographic and rural-urban disparities.

It is too soon to evaluate the impact of the New York and California abortion training initiatives. However, these initiatives represent an attempt to implement the requirements of the ACGME to provide OB/GYN residents with comprehensive reproductive health training. A study published in 1999 found that 57% of obstetricians and gynecologists who performed abortions were 50 years or older. Replacement of abortion providers who are approaching retirement age depends on training a new generation of clinicians. Improved implementation of the ACGME training requirements has the potential to impact the future of abortion services and address the regional disparities in access.

REFERENCES