The Impact of Abortion Training

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A Qualitative study to assess abortion provision after residency among those who had access to integrated abortion training

Research Question

Training Up

BUT

# of Providers Down

What dissuades doctors from continuing to provide abortion care?

In-depth interviews in 2006

Primary Sample (n=30):

West (9)

Midwest (9)

South (5)

Northeast (7)

- Graduates 1996-2001
- 4 Ob-Gyn Residencies with Integrated/Routine Abortion Training

In-depth Interviews in 2006

Secondary Sample (n=10):

Residency Directors

Family Planning Fellows

Administrators

Other OB-GYNs

The Usual Suspects

Protester Conflict

Violence

Moral Discomfort

Results

Of the primary sample of 30 graduates:

- 3 providing abortions for any reason
- 5 for maternal or fetal indications only
- 3 for fatal fetal indications only

Barriers Cited by Willing Physicians

- Stigma –fear loss of business
- Employer Intimidation
- Workplace restrictions/prohibitions
- Organization/cost of services

Stigma

- Small town "abortionist" lore
- Community pressure
- Fear of professional failure

Intimidation

Threats and harassment from

- Superiors
- Potential employers
- Patients
- Pharmacists

Workplace Restrictions

- Group private practices
- HMOs
- Surgery centers
- Hospitals

Cost and Systemic Referral

- Efficient, cost-effective abortion clinics in urban areas and mid-sized cities

Conclusions

- Fear of business failure
- Fear of conflict
- Low autonomy
- Abortion Care must be a HIGH PRIORITY

Medical Liability Insurance as a Barrier to the Provision of Abortion Services in Primary Care

Christine Dehlendorf, MD, MAS

A family physician wants to provide medication abortion in his primary care practice, and talks to his insurance company…

"Our determination is that this procedure will be covered for OB/GYN physicians only. We do not believe this falls within the accepted scope of practice for a Family Physician, and therefore will not cover a family physician who provides Mifepristone in their [*sic*] practice."

(R. Morrow, written communication, May 2006)

Scope of the Problem

- Both aspiration and medication abortion coverage denied to non-ob/gyns
- Even if covered:
  - Abortion rider costs $10,000 - $15,000
  - Medication abortion treated similarly to aspiration abortion

What does this mean?

- Is abortion in the scope of practice of family medicine?
- What are the liability risks associated with first trimester abortion?
- What are the public health implications?

Abortion in Primary Care

- First trimester abortion within scope of practice for family medicine
  - In 1997, 18% of NAF members family physicians
  - AAFP guidelines list abortion as an advanced skill
  - The safe and effective provision of medication and aspiration abortion by family physicians has been extensively described in the literature

Liability Risk with First Trimester Abortion

Abortion Related Medical Liability Payments, 1996-2005*	
Payments, no.	756
No. payments per millions abortions	53.62
Median payment (25%, 75%)	$88,037 ($27,225, $235,950)
Amount of liability payment per abortion performed	$ 11.11

- Numbers of procedures are reported for a range five years prior to that of payments due to the delay from the time of the incident to the time of the report to the National Practitioner Databank.
- Data from Dehlendorf and Grumbach, AJPH 2008.

Why is there a disconnect between the data and insurance companies' actions?

- Business as usual?
- Singling out reproductive health services for special treatment not uncommon
  - No justification for denial of coverage to family physicians
  - No justification for treating medication abortion the same as aspiration abortion

What are the implications?

- A barrier to the ability of trained and willing providers to provide abortions
- And more generally, raises the questions:
  - Do insurers have the right to define scope of practice?
  - Can insurers decide coverage on a medication by medication basis?
  - Can insurers be held accountable to the effect of their actions on public health?

What can be done?

- Medical specialty organizations should advocate for evidence based, equitable coverage
- State governments can increase oversight of rate setting process
- Individual insurance companies can voluntarily work to ensure that their coverage decisions do not negatively impact on public health

Barriers to the Provision of Second-Trimester Abortion Care

Susan Yanow, MSW

Second Trimester Abortion Access Network

Incidence of Second-Trimester Abortion

Weeks	Abortions Performed	
	% of total	#
≤ 8 wks.	60.5%	513,139
9-10 wks	18.0%	152,669
11-12 wks	9.7%	82,272
13-15 wks	**6.2 %**	**52,586**
16-20 wks	**4.2%**	**35,623**
> 21 wks	**1.4%**	**11,874**

CDC, 2003

How late in pregnancy abortions should be permitted and carried out is a matter of great controversy among almost everyone –

except the women who need them.

- Marge Berer, Int'l Consortium on Medical Abortion

Barriers for Clinicians

1. Training issues
2. Need for professional support
3. State facility regulations/TRAP laws
4. Financial issues
5. Lack of public and personal support

Training Issues

- Lack of training sites
- No consensus on what is “trained to competency
- Need for volume to keep skills up

Training: Increasing but Still Limited

Ob/gyn programs with routine abortion training

- 50% of residents receive training in D&E
- Less than half perform more than 10 procedures

Ob/gyn programs with optional abortion training

- Only 14% of residents are trained in D&E
- Fewer than 18% perform more than 10 procedures

Professional Support Required

- Hospital back-up must be available in order to provide later procedures
- A team of other professionals, including nurses and anesthesiology, are required for later procedures

TRAP Laws

- 6 states require that 2nd-trimester abortion providers meet the states' standards for ambulatory surgical facilities:
  - Georgia, Indiana, Mississippi, Missouri, New Jersey, and Virginia
- 4 states require that 2nd-trimester abortions after a particular gestational age be performed in ASCs:
  - Illinois (post-18 weeks), Rhode Island (post-19 weeks), South Carolina (18 weeks), Texas (post-16 weeks)

Financial Issues

- Malpractice issues
- Inadequate insurance/Medicaid compensation

Lack of support

- Public
- Professional
- Personal

Potential Solutions

1. Training Issues
2. Need for Professional support
3. State facility regulations and TRAP laws
4. Financial issues
5. Lack of public and personal support

Increase Training

- Explore how existing academic sites could increase gestational limit & training capacity.
- Develop a consulting/technical assistance team
- Export successful hospital and clinic models and training teams

Training is “Step One”

Develop programs to increase probability of providing:

- Incentive programs (loan repayment)
- Identify and provide support for becoming a regional abortion specialist
- Teach practice management skills during training
- Provide individualized support to overcome obstacles to integrate abortion into practice

Professional Support

- Increase training and education for RNs, APCs, and anesthesiology
- Engage in our professional associations and build support for second-trimester services and providers

Remove Harmful Regulations

- Work within ACOG to rescind post-18wk ACS guidelines
- Educate legislators about the need for second-trimester abortion
- Remove barriers for skilled non ob/gyns who have been trained to provide later abortions

Financial Issues

- Fix the malpractice system
- Make Medicaid/Medicare work by establishing experts to help providers navigate the system and work for higher reimbursement rates, track down payments, etc.

Provide Support

Increase attention to the psycho-social needs of trainees, trainers, and all members of the second-trimester abortion team.

Support for Trained Clinicians: Overcoming Barriers to Practice

Mitchel Hawkins

Past and Ongoing Efforts

- Supporting Providers
  - Abortion Access Project: Supporting providers in rural and underserved areas
- Educational Resources
  - ARHP: Continuing education and CME
  - Reproductive Health Access Project—Educational opportunities and one-year faculty development fellowship
- Innovations in Training
  - HWPP (APC) Project
  - TEACH, RHEDI, Ryan …

Ryan Post-Residency Support Program

- Pilot program to support physicians trained in residency
- Program activities will be shaped by survey of recent graduates

Proposed PRS Activities

- Web-based resources: contract negotiation, malpractice rights, etc.
- One-on-one support: linking graduates with peers and more experience providers
- Online support through social networking
- Educational interventions:
  - improving residency education to prepare graduates to face future obstacles