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Abortion providers in the United States: expanding beyond obstetrics and gynecology

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Abstract

In the years preceding the *Dobbs v Jackson Women's Health Organization* (2022) decision, there had been a shift in the demographics of abortion providers. Although most abortion providers were obstetricians-gynecologists, there had been a rapid increase in the number of internal medicine and family medicine physicians and advanced practice clinicians providing abortion care. As discourse about limiting abortion access has gained volume over the past few years, so have the number of legislative restrictions aimed at preventing people from seeking abortions. Among these are laws and policies targeted at reducing the number of providers and clinics providing abortion care, resulting in an absence of training, high case volume, and institutional restrictions. With the overturning of *Roe v Wade*, the landscape of abortion provision will continue to shift further. Action needs to be taken to expand the types of providers getting trained and providing abortions to ensure access for those seeking abortions.

Key words: abortion, abortion restrictions, advanced practice clinicians, family planning, medical education, medical law, reproductive rights

Introduction

Even before the historic strike down of *Roe v Wade* in June 2022, state and federal legislations had long politicized abortion through targeted regulation of abortion providers (TRAP) laws. In 2013, Texas implemented TRAP laws, which required abortion-providing physicians to have admitting privileges at nearby hospitals and facilities providing abortion care to meet the regulatory standards of ambulatory surgical centers. Subsequently, more than half of the clinics in the state were forced to close because of their inability to adhere to these strict provisions.[1] According to the Guttmacher Institute, the total number of abortion providers—defined as a hospital, clinic, or physician's office where abortions are performed—dropped by 5% in the period between 2014 and 2017.[2] As seen in Texas and elsewhere in the country, legislative restrictions severely limit the availability of healthcare providers and clinics, which, in turn, limits their ability to provide abortion care. To combat this, abortion care needs to expand beyond the scope of practice of solely obstetrician-gynecologists to include more internal and family medicine (FM) physicians and advanced practice clinicians (APCs). Many APCs are already present in rural areas and serve underserved populations and are well practiced in family planning services.[3] There are data from 2001 citing significant FM physicians' involvement in abortion care,[4] and an organization named Reproductive Health Education in Family Medicine (RHEDI) was founded in 2004 to advocate for abortion care as atpdel component of FM.[5] Ultimately, expanding the types of providers that are getting trained and providing abortions is crucial for ensuring access to and meeting the needs of people seeking abortions.

Changes before the fall of *Roe v Wade*

When the *Roe v Wade* ruling was decided in 1973, the landscape of abortion care in the United States began to change. Abortion rates rose rapidly, peaking in the late 1970s to 1990s. However, not all physicians were providing abortion care. A survey from 1985 found that despite 84% of gynecologists believing that abortion was necessary in some cases, only 34% performed the practice.[6] The provision of abortions historically has fallen mostly to obstetrician-gynecologists, but there has always been some involvement of FM physicians in this space. A survey of National Abortion Federation (NAF) members in 2001 revealed that, of 278 respondents, 62.9% were obstetrician-gynecologists, 20.5% were FM physicians, 7.2% were general practitioners, and 8.3% were nonphysician providers or other.[4] In the period between 1980 and 2014, the abortion rate in the United States decreased by more than half, mostly, in part, because of the increasing use of contraceptives.[7] Only 7% of surveyed obstetrician-gynecologists reported providing at least 1 abortion in 2013 or 2014.[8]

Of note, abortion rates continue to fall. According to the Centers for Disease Control and Prevention Abortion Surveillance from 2020, the abortion rate decreased by 18% from 2011 to 2020, hitting a record low in 2017.[9,10] Unlike in the past, the decline in abortion rates since the 2010s cannot be attributed to improvements in contraception usage or can it be attributed to safety concerns. The national case fatality rate for legal induced abortion was 0.43 deaths per 100,000 reported legal abortions between 2013 and 2019, the lowest it has been for previous 5-year periods.[9] The mortality risk of having an abortion is lower than that of childbirths, colonoscopies, plastic surgeries, dental procedures, and adult tonsillectomies.[7] Despite this, there has undoubtedly been growing resistance to abortion access for many years before the passing of the 2022 *Dobbs v. Jackson Women's Health Organization* decision, which is likely reflected in the falling abortion rates and the percentage of providers who have performed the procedure in practice.

Efforts to limit abortion access began as early as the *Roe v Wade* decision in 1973. States attempted to impose strict regulations on abortion clinics, but many of these were struck down by lower federal courts.[11] In retaliation, beginning in the early 1980s, states searched for other ways to restrict abortion access, for example, imposing limitations on public funding.[11] In the 1990s, endeavors to use clinic regulations to limit access to abortion resurfaced and have become prominent since 2010.[11] Between 2017 and 2020, 25 states enacted abortion restrictions that could not yet go into effect because of legal challenges.[12] The overturning of *Roe v Wade* in June 2022 subsequently allowed these sweeping restrictions to be enacted, including near-total abortion bans in approximately 13 states.[13] Before this dramatic change, TRAP laws were already greatly limiting providers' ability to practice, especially in maintaining admitting privileges. Moreover, some laws required the same physician to complete both the patient's ultrasound and the abortion procedure, but providers describe difficulties managing this case volume.[1] The *Dobbs* decision has been instrumental in allowing states to have full jurisdiction over abortion legality. It has let regulations in restrictive states that were passed under the pretense of making abortions medically safer to become regulations that limit abortion care.

The role of obstetrician-gynecologists and complex family planning specialists

Traditionally, abortion care has mainly fallen under the scope of practice of obstetrician-gynecologists, who are trained in all aspects of reproductive healthcare. A 2018 study found that 75% to 85% of first- and second-trimester surgical abortion providers are licensed obstetrician-gynecologists.[14,15] In 1996, the Accreditation Council for Graduate Medical Education (ACGME) formally mandated that obstetrician-gynecologist residency programs provide comprehensive

abortion training.[16] Soon after in 1999, the privately funded Kenneth J. Ryan Residency Training Program in Family Planning and Abortion was launched as an initiative to help integrate comprehensive abortion and contraception care into obstetrician-gynecologist residency programs across the United States.[16] More recently, in 2020, the ACGME accredited a 2-year Complex Family Planning Fellowship, which obstetrician-gynecologist residency graduates may apply for. Board-certified comprehensive family planning specialists are uniquely equipped to provide care in more medically complex abortion care cases.[17] For example, a patient seeking an abortion further along in pregnancy, someone who has a history of multiple cesarean deliveries, or a patient who has an abnormal placental variant may benefit from seeking out care with a complex family planning specialist. Currently, there are 29 family planning specialties across the United States and limited access to providers diffusely across the country.[18] To meet growing abortion care gaps today, it remains crucial that the ability to provide abortions be expanded beyond the field of obstetrics and gynecology to include other physicians and APCs. This will help lessen the burden on family planning providers to focus on more complicated cases for which they have proper training and expertise.

The role of internal and family medicine physicians

As abortion care continues to be restricted, having physicians from other specialties, such as IM and FM physicians, trained in abortion care is instrumental to facilitating access to abortion services. Especially in rural areas, FM physicians are crucial providers of all healthcare, including abortion care. There is a clear need for FM physicians to provide such services.

The role of FM physicians has become even more crucial as the provision of abortion care shifts out of hospitals to nonhospital clinics, particularly in the form of medication abortion.[19] However, there are barriers in place preventing FM physicians from providing these services. Most FM physicians report feeling inadequately prepared to provide a pregnancy termination after graduating from residency because of a lack of exposure to the process. In 1 survey of FM physicians, only 3% of survey respondents reported providing a pregnancy termination.[20] Many of the barriers faced by FM physicians are the same as those experienced by other abortion care providers, such as absence of training, institutional restrictions, costly liability insurance, unsupportive professional and peer networks, and fear of violence or harassment.[21] TRAP laws, such as the one mentioned earlier requiring abortion-providing physicians to have admitting privileges at nearby hospitals, also restrict the ability of FM physicians to provide abortion care in rural areas or in clinics that are not affiliated with a hospital.[1]

As rates of medication abortion (MAB) increase, it becomes more evident how IM and FM physicians fit within the sphere of abortion care. In 2020, MAB accounted for 54% of all US abortions.[2] In a study done by Wolgemuth et al,[22] 44% of surveyed IM physicians believe MAB is within their scope of practice. There are currently more than 150,000 general internists and FM physicians practicing in the United States—even if only a fraction of these providers were consistently providing abortion care, it could dramatically increase the number of eligible abortion care providers.[23] Previously, abortions used to nearly always require minor procedures, such as dilation and curettage, that required the surgical training and technique of an obstetrics and gynecology physician. With the introduction of medication abortion, the same surgical expertise is not as necessary for all types of abortions. This means that physicians, such as IM physicians, can still provide abortion care even without a surgical background, reducing the barrier of additional training to acquire the skills needed to perform a surgical abortion. With increased exposure to abortion provision training and education, IM and FM physicians can feel even more empowered in their ability to provide abortion care.

The role of advanced practice clinicians

The shortage of physicians trained and willing to provide abortions leaves room for nurse practitioners, physician's assistants, and other APCs to provide abortions. As mentioned earlier, a survey of NAF members in 2001 found that, of 278 respondents, approximately 91% were physicians and approximately 9% were nonphysician providers or other.[4] In the United States, there are many legislative and financial barriers preventing APCs from providing abortion care. In 2021, according to the Guttmacher Institute, 36 states, particularly in the South and Midwest, already required abortion to be performed by a licensed physician.[13]

However, California has been a leader in allowing APCs to provide abortions, passing a law in 2002 that expanded the types of providers eligible to perform abortions.[24] California's success shows that allowing APCs to perform abortions can increase the number of clinicians providing abortions. This motion has prompted the reintroduction of abortion care to primary care clinics and community health clinics in California and has helped reduce the stigma for people attending these clinics.[24] As restrictions on physicians who provide abortion care increase and the importance of APCs in medicine grows, laws that limit the scope of care that APCs can provide need to be revisited.

Changes after the fall of *Roe v Wade*

In the time since the strike down of *Roe v Wade* protections in June 2022, abortion care has already been eliminated in many states. At this current time, at least 13 states have instituted a total or near-total ban on abortion care, and further restrictions are pending.[13] Currently, only 16 states plan to continue to protect the right to abortion care for patients.[25] Although there is little research yet about how the striking down of *Roe v Wade* will change the demographics of abortion providers, it will certainly have a lasting effect. Many Southern states, which have already been suffering from a shortage of family planning care, will lose abortion providers as their clinics are forced to close.[1] This will disproportionately affect marginalized communities, especially people of color, which Southern Black abortion providers are already calling attention to.[26] In this post-*Roe* America, as states outlawing abortion continue to lose their abortion providers, the demographics of family planning providers will see a massive shift.

The impact on medical training

Many medical training programs already lacked formal education in abortion practices even before *Roe* was overturned.[27] Only 64% of obstetrics and gynecology residency programs offer routine abortion training,[28] and 96% of abortions occur outside of the traditional learning environment of the medical student.[29] The American College of Obstetricians and Gynecologists (ACOG) advocates for increased education and training in abortion care to increase the availability of trained abortion providers.[30] With the inauguration of a newly accredited complex family planning fellowship in 2020, more avenues have been introduced for obstetrician-gynecologists to gain more specialized training in abortion care.[17] ACOG currently recommends implementing a requirement that all obstetrics and gynecology residency programs provide opt-out abortion training.[30] Moreover, the ACGME has recently reaffirmed that every obstetrics and gynecology resident should be trained to perform abortions using both surgical and nonsurgical methods.[31]

With the fall of *Roe v Wade*, abortion care training has been dramatically reduced. Currently, nearly half of obstetrics and gynecology residency programs are located in the 26 states likely to restrict abortions. This reduces access to training for 2638 residents.[32] One-third of the 89 Ryan Programs are in restrictive states with strict abortion laws.[33] These statistics do not include residents in other specialties, such as the 42 of 745 total FM programs that offer abortion training, whose education will also be affected by the *Dobbs* decision.[32,34] Newly imposed restrictions will further limit the opportunities for those trainees to learn how to provide lifesaving medical care. Despite these restrictions, the ACGME has not lightened on its requirement for abortion training as a mandatory component of accredited obstetrics and gynecology residency programs.[33] Alternatively, it has mandated that if a program is in a

jurisdiction where abortion care "is unlawful, the program must provide access to this clinical experience in a different jurisdiction where it is lawful."[35] This has forced some obstetrics and gynecology residents who are unable to fulfill their ACGME requirements to complete rotations in states that still allow abortions and has left programs scrambling to find accommodations to maintain their accreditation status.[33] However, coordinating students to train in different locations is associated with its share of complicated logistics and financial hurdles. Schedules need to be coordinated, program letters of agreement need to be completed, and liability insurance coverage needs to be provided through the home program.[33] Moreover, there are significant legal implications for physicians traveling out of state to provide abortion care.[33]

Much of medical training is focused on the model of learning through observation and experience. Restrictions on abortions will limit the opportunities for medical trainees to gain exposure to providing abortion care. The current social and political environments regarding abortions may push students and residents interested in reproductive health to seek training in states with abortion-friendly legislation. Such trends will only exacerbate the current disparities seen in the availability of abortion services. At an extreme, the overturning of *Roe v Wade*, and the subsequent diminution of provider autonomy, runs the risk of discouraging students from pursuing careers in reproductive health in general.

Call to action

Action needs to be taken to increase the number of trained abortion providers and to permit providers to be able to provide abortion care. First, abortion training needs to be strictly implemented in obstetrics and gynecology training programs by national organizations, such as ACOG and ACGME. For residents training in regions where abortion care is limited, funding and resources need to be provided to facilitate their training elsewhere.

Second, training needs to be expanded to include abortion providers from other fields, including APCs, IM, and FM physicians. This includes supporting groups, such as Medical Students for Choice (MSFC), RHEDI, and the Ryan Program that advocate for the integration of abortion training into medical school and residency programs. Obstetrics and gynecology clerkship directors of 78 accredited medical schools reported that 45% of third-year rotations offered a clinical experience in abortion care and approximately half offered a fourth-year reproductive health elective; however, participation in both was low.[36] To combat the lack of exposure to abortion training in medical schools, the MSFC has organized programs, such as the Reproductive Health Externship Funding Program and Clinical Abortion Observation, to provide students with this experience.[37] A survey of MSFC alumni found that 31% of alumni in obstetrics and

gynecology or FM are providing abortion care in their practice,[38] compared with 7% of surveyed obstetrician-gynecologists reporting providing at least 1 abortion.[8] These MSFC alumni who are providing abortions are located all over the United States, residing in more than 30 cities, with 16% providing services in rural communities.[38] As for support in residency programs, a survey of FM residents before and after their RHEDI training revealed that the rate of residents who had performed any abortion increased from 15% to 79%, with an increase in reported self-rated competency in abortion care.[39] These programs have proven how their effect is greatly influential in increasing opportunities for students and residents in training to gain exposure and familiarity with providing abortions.

For those trained, further measures need to be enacted to allow them to practice. For FM physicians providing MAB, specifically, the risk evaluation and mitigation strategy (REMS) criteria for mifepristone need to be revisited. REMS programs are implemented by the US Food and Drug Administration (FDA) to prevent, monitor, and manage specific risks associated with certain drugs by reinforcing actions to reduce the frequency of possible adverse events.[40] The REMS criteria mandate that clinic administration approves the usage of the drug. Of note, 1 study has found that this additional step introduces new barriers to FM physicians who provide abortions.[41] Clinical administration can be unsupportive in approving and the complexity of navigating the REMS makes MAB not seem worth the effort. A recent revision to the REMS criteria for mifepristone in January 2023 permanently removed the requirement that pharmacies must dispense mifepristone to patients in person, allowing the medications to be delivered to patients via mail.[42] Although this does increase some access to MAB, the FDA has maintained the requirement that only certified healthcare providers can prescribe mifepristone and that the prescriber, patient, and pharmacy must all complete agreement forms for the medication to be dispensed.[42,43] Removing the REMS criteria altogether, as organizations, such as ACOG,[43] the American Medical Association,[44] and the American Academy of Family Physicians,[45] advocate for, could remove these additional barriers and further streamline the process.

In addition, there needs to be a push to allow mifepristone administration via telehealth appointments. Currently, 15 states require patients to have at least 1 in-person visit before being given MAB.[46] This is different from the update to the REMS criteria that has eliminated the need for an in-person trip to the pharmacy to obtain mifepristone for MAB. These states require an in-person consultation with the provider before the drug can even be obtained. However, clinically, an in-person visit is not indicated for the prescription of MAB. Offering MAB via telehealth can greatly increase access to abortion care, especially for patients living in more rural areas or states with harsher restrictions.

Although clinical training alone may not be sufficient for providers to overcome some barriers to providing abortion care, increasing access to training at least addresses 1 bottleneck in the number of eligible abortion providers.[47] Beyond this, there needs to be a push for support networks for providers who deliver abortion care and continuing advocacy to fight the many ways in which abortion rights have been targeted.

Conclusion

With the overturning of *Roe v Wade*, patients will be harmed by a loss of access to abortion care. The barriers placed on abortions not only impose difficulties on patients seeking abortions but also reduce the ability of medical students and residents to gain appropriate training in the provision of abortion care. Medical students and residents in states with tightening restrictions who lose out on crucial training will be limited in their ability to provide this care throughout their careers, affecting clinical care for decades. Obstetrician-gynecologists, who provide most abortion care, will feel the effect of these constraints on their clinical practice, deterring them from providing such services. As restrictions around providing care tighten, the role of non–obstetrics and gynecology physicians and APCs will become even more crucial in continuing abortion provision. Further research should compare the training and different specialties of abortion providers in both restrictive and nonrestrictive states to elucidate these changes. Ultimately, training more providers in abortion care is of utmost importance in increasing access to abortions for patients across the country. As MSFC declares, "Without providers, there is no choice. Without education, there will be no providers."[48]

Footnotes

The authors report no conflict of interest.

Patient consent is not required because no personal information or detail is included.

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