

access

success

NARAL/NY's

Residency Training Initiative

Success In New York City's

Public Hospitals

a campaign

local in approach—
national in effect

to the physicians who make our

freedom possible

about naral/ny

NARAL/NY is the New York State affiliate of the National Abortion and Reproductive Rights Action League. With more than 30,000 members, NARAL/NY works to protect safe, legal, affordable and accessible abortion care and expand the full range of reproductive rights for all New Yorkers, regardless of age or income. The NARAL/NY Foundation is the 501(c)(3), tax-exempt research, educational and training arm of NARAL/NY. The Foundation produces a variety of educational materials and training programs to educate members, advocates, and the general public about reproductive rights issues.

staff

access success

NARAL/NY
Residency Training Initiative's
New York City
Public Hospital Campaign

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a new threat on the horizon

“We will only meet this challenge of creating the next generation of providers if physicians and pro-choice advocates work together and embrace each other’s strengths.”

In the early 1990s reports began surfacing that confirmed what reproductive health advocates had feared:

the number of abortion providers in the United States was dwindling.

Women in most parts of the country (86% of counties) had no abortion provider locally.¹ Young women, poor women, and women in rural areas were most severely affected — having to travel long distances, sometimes needing to stay overnight and, in addition to these travel expenses, pay for lodging in order to obtain an abortion. This added burden often caused women to seek services later in a pregnancy, increasing the cost and complexity of the procedure. The image emerging was alarming: abortion, the second most common surgical procedure performed in the United States,² was becoming out-of-reach for many women because the physicians offering this care were disappearing. Between 1988 and 1996 we had lost 22% of our nation's providers — and that trend looked likely to continue.³ In 1995, 50% of our abortion providers were age 50 or older.⁴ Each year we lose 85 providers (out of 2000) to retirement with no replacement.⁵ Estimates predict that by the year 2012 we could face the very sobering prospect that women would seek this care from half as many providers as women do today.

A new reality dawned for many women's health and pro-choice advocates: keeping abortion legal would become only *half* the struggle.

Awareness of the abortion provider shortage coincided with a wave of anti-abortion terrorism and intimidation campaigns throughout the United States. Many who reported on the abortion provider shortage assumed that its cause was inextricably linked to the increase in harassment and violence. Clinics across the country

were surrounded by highly organized protests, symbolized by Operation Rescue* launching creative and effective campaigns to disrupt the ability of clinics to deliver women abortion care. But with the election of President Clinton, and the passage of federal clinic access laws that deterred protesters from blocking entrances to health care facilities, the mobs outside of clinics subsided. What emerged in place of the protestors were a few anti-abortion extremists willing to resort to the ultimate intimidation tactic to get their way: terrorism. Clinics were bombed. Physicians and clinic staff were murdered. Violence against abortion providers increased five-fold during the Clinton presidency.⁶ The media coverage crystallized one image in the public's mind: To offer patients abortion care in the late part of the twentieth century was to put one's life on the line.

Yet, in reality, intimidation campaigns may not have been the major cause of the abortion provider shortage. Sadly, the provider shortage may have fueled the anti-abortion terrorism.

When opponents of abortion recognized that there were fewer doctors to target, their intimidation campaigns grew focused and became frighteningly personalized.

Indeed, a closer look at the provider shortage problem revealed that most of the doctors ending their abortion provision were not doing so because of fear but rather because of age. What researchers discovered was that older doctors, those over age sixty-five, were twice as likely as their younger counterparts, those under age forty-nine, to offer women abortion services.⁷ This was the basic root of the abortion provider shortage. Physicians leaving the abortion provider ranks were retiring from the medical profession altogether,

*Operation Rescue, an anti-abortion "direct action" group, formed in 1986 to blockade clinics and disrupt abortion services. Operation Rescue exists today under the name "Operation Save America."

not just deciding to stop offering one type of health service. When they retired, the next generation did not fill their ranks in equal numbers. Most interesting, non-providing younger doctors were also not claiming objection or fear as the reason why they were not offering abortion services to their patients. Instead, these doctors were much more likely to cite “lack of proper training” as the reason for not becoming an abortion provider.⁸

Opponents of abortion were not solely responsible for the provider shortage; they simply took advantage of it. Many in the pro-choice community began to acknowledge that the more likely cause of the abortion provider shortage, ironically, could be discovered in trends motivated by the pro-choice movement over several decades. The success of the private, free-standing, clinic model for abortion which originated in order to provide women patients with quality, efficient, affordable and patient-focused abortion services, moving abortion services out of hospitals, was largely why younger physicians were not being trained in abortion services and, in turn, why they were not becoming abortion providers.

the generational difference

Doctors trained in the 1970s, were more likely to have had routine training in abortion services during their residency in teaching hospitals than physicians trained a generation later. Physicians in residency in the years before the legalization of abortion routinely witnessed the dramatic toll women paid for illegal abortion. For example, in the late 1960s, one in every four admissions to the Ob/Gyn department of a public hospital in New York City was for the care of a botched abortion.⁹ Resident physicians being trained in these hospitals witnessed the need for safe abortion services and were regularly required to perform abortion techniques to care for complications arising from illegal abortion. After abortion was legalized in 1973, eighty percent of abortion services took place in hospitals.¹⁰ In the 1970s, more medical residents had routine access

to abortion training, understood the frequent need for abortion services, and graduated with a commitment to offering safe abortion services to patients. In 1978, more than one in four Ob/Gyn residency programs offered routine first trimester abortion training. In 2002, only seven percent of hospitals in the United States even offer abortion services. By 1994, slightly more than one in ten Ob/Gyn residency programs offered routine first trimester abortion training.¹¹ Physicians coming out of residency in the seventies were twice as likely to have had access to abortion training as physicians coming out of residency in 2002. Abortion training is not offered at all in 30% of the nation’s Ob/Gyn residency programs.¹²

The rise of private clinics offering abortion services that took place over the past thirty years removed abortions from the hospital setting and, as a result, from the site where Ob/Gyn residents receive almost all of their training. The success of the freestanding abortion clinic model — which offered women high quality, ambulatory, and affordable abortion care — unintentionally prevented new generations of physicians from having adequate training opportunities in this most common procedure. It also altered the way a generation of physicians viewed abortion services.

Young physicians no longer witnessed, as their predecessors had, the prevalent need for abortion services.

Few know it to be the second most common surgical procedure performed in the United States. Also, most of the major advancements in abortion care, which offer women more mild pain management methods and access to termination services in the earliest stages of pregnancy, were developed at abortion clinics which, as specialists in this care, were dedicated to assuring their patients had access to the earliest and safest care. The decline in

hospital-based abortion care led to a downward spiral; with less abortion services being delivered, hospitals were less motivated to implement changes to improve care and training. The quality of hospital-based abortion services remained frozen in time over the past three decades, immune from advancements, untouched by modernization.

The few abortion services that take place in the hospital setting today are often for patients with complications that require more complex procedures. Many hospital-based abortion cases are driven by medical need. For example, women with asthma, or obesity, or carrying a fetus with severe abnormalities, will require specialized care. These procedures occur in an operating room setting where the only pain management method available to patients is general anesthesia. Even medical residents who have access to abortion training within their residency are seeing the few procedures available in an archaic setting, with pain management methods only specialists can offer, on patients with extreme needs. These experiences are certainly not replicable in their future private practices. The earliest and most modern abortion methods are not available for patient use or for resident training because most hospital-based abortion procedures are only located in operating rooms. Abortion, one of the first ambulatory surgeries, that led many other surgeries into outpatient care, is today one of the only simple surgeries in the hospital that has not been moved and modernized out of the operating room.

a focused attempt to address the abortion provider shortage backfires

In 1995, after the publication of national studies detailing the dramatic decrease in access to abortion training for Ob/Gyn residents, several efforts were launched to address the training and provider shortage problem. The Accreditation Council for Graduate

Medical Education (ACGME), the accrediting body for medical residency programs, created clear abortion training requirements, which also allowed for residents with objection to opt-out of training, in order to address the abortion provider shortage. In 1996, the requirement was nullified by Congress, which allocates federal funding to ACGME-accredited medical institutions, after a fierce campaign by anti-abortion forces. The ACGME was forced to scale back its requirement, announcing, “No program or resident with religious or moral objection shall be required to provide training in or to perform induced abortions. Otherwise, *access to experience with induced abortion must be part of residency education*” (italics added).¹³ It was a confusing moment for women’s health advocates. Certainly, the emphasis on abortion training was hopeful but, in this now watered-down mandate, what did “access” really mean? Does access mean that if one abortion happens in the hospital all year, and it is the only procedure an interested resident sees before graduation — the question becomes: did “access” really happen? And did anything really change? Would “access” mean that residency programs could point residents to clinics where training might be possible, but it would be training that only a few dedicated residents would pursue outside of their already demanding schedules?

Does “access” mean that residents would be expected to routinely rotate through a modern abortion service, with an adequate supply of training opportunities, and graduate proficiently skilled to offer this care if they choose? If this was the case, were residency programs expected to modernize the delivery of abortion care within the hospital in order to give residents adequate and appropriate training opportunities? If so, by when? It was difficult to determine what the new requirement meant and, after the Congressional brouhaha, clarification from the ACGME was not forthcoming. Many programs, naturally, read the new requirement to mean that they were in compliance — after all, one abortion happening each year at a facility did qualify as “access” by some

definitions, and suggesting a resident with vocal interest contact an abortion clinic to arrange training on their own time did as well. The ACGME's emphasis on abortion training was beneficial, and underscored the procedure's significance. Yet, the vague language of the requirement rendered it unenforceable.

In an effort to expose residents to adequate training opportunities, several private abortion clinics throughout the country did offer their sites to residency programs for resident training. Some programs agreed to this arrangement and informed their residents that training in abortion was available through the clinic. This established another interpretation of "access to abortion training" and offered, what may seem at first, a convenient way for programs without a sufficient volume of abortion services to comply with the new regulation. However, the vast majority of residents did not, could not, and do not, take advantage of training opportunities off-site. And while clinics were able to provide residents with a high volume of modern abortion procedures in which to train, the barriers of having the training occur outside the residency program setting, on a resident's own time, without the supervision of familiar faculty, gave many residents the impression that abortion was not part of mainstream medical care. It cast elective abortion procedures as not vital enough services to learn routinely within their formal rotation. For many, the 80, 90, or 100 hour or more workweek was enough to dampen any enthusiasm that might lead them to travel, off-site, to a clinic for training. There is no other commonly needed gynecological procedure for which training is presented this way. Mostly, it was only the most committed residents who took advantage of the private clinic training opportunities.

Over the last decade, many researchers have focused on finding what prompts some residents to go on to offer abortion care in their practices, while others do not. The studies have found similar trends among residents who do become abortion providers. Physicians who receive training within their residency program are

more than twice as likely to provide abortion services than physicians who do not receive training during residency (49% vs. 21%).¹⁴ When training is presented as a routine (expected) part of a resident's rotation more than one-half of residents participate, and 97% of programs report a participation level of more than three-quarters. In contrast, of programs that present abortion training as "optional" (available to residents who express interest), only 53% had more than half of residents participate in the training, and only 29% of the optional programs reported that more than three-quarters of residents participate.¹⁵

In other words, when abortion training is required and regularly available within a residency program, twice as many physicians get trained and twice as many go on to become providers.

Having *routine* abortion training occur within the teaching hospital, which is the *traditional Ob/Gyn resident training setting*, is the most important factor in assuring physicians graduate proficient in and committed to offering abortion care. These two principles guided the work of the NARAL/NY Foundation.

a small staff with a big plan

“This initiative, if brought to bear elsewhere, might help produce a generation of doctors qualified to provide abortion, surgical and medical, ably and safely.”

— *The Washington Post*, May 5, 2002

The NARAL/NY Foundation launched the Residency Training Initiative in 1998 to establish, improve and expand access to modern abortion procedures in Ob/Gyn and family medicine residency programs. Assuring that future generations of physicians are available and able to offer safe abortion services became a new part of the small staff's mission. Early research uncovered an important piece of information: NARAL/NY was serendipitously located in the resident training capital of the country — one in seven (or 15%) of the nation's doctors graduate from New York residency training programs.¹⁶ Even more ideal for the small staff was that 86% of the state's Ob/Gyn residency programs were based in New York City, as were we.¹⁷

step one:

identifying allies in the academic medical community

The first step for the fledgling project was to identify the availability of training in New York City programs. Residency Training Initiative staff began by making calls to Ob/Gyn residents on duty within New York City hospitals. Residents are notoriously busy people, so staff worked around residents' schedules and arranged phone interviews to discuss the state of abortion training within several programs. Residents were granted anonymity to assure their comfort in offering honest accounts of the state of abortion services. Residency training directors of several programs were also interviewed to obtain the most comprehensive perspective. These conversations provided Residency Training Initiative staff, which had no formal medical training, a primer on medical lexicon, important insights into how abortion care was organized in a hospital-based setting, and an overview of the abortion training problem.

A disturbing portrait emerged based on these conversations. In several hospitals, residents reported difficulty accessing abortion

training even though abortion services were taking place at the teaching facility. The most egregious account came from a resident at SUNY Downstate, which rotates its residents through Kings County Hospital, a New York City public hospital, for a significant portion of their training.

The resident reported that even though the facility did well over 2000 elective abortions per year, making it one of the largest hospital abortion providers in the country, residents were only trained in emergency abortion procedures which were infrequent and took place in the hospital operating room.

Abortion was not a required part of the curriculum for Ob/Gyn residents and only two out of 21 residents sought training in the procedure. These residents, of which she was one, were disparaged by their peers and referred to as the "terminators". Her sense was that their former residency director who was no longer employed by the hospital had encouraged the negative environment. She believed the atmosphere for training had improved as a result. Residents interested in learning abortion care had to seek training on their own time and the average resident already worked 80 hours per week. Finally, she reported, the service at Kings County was archaic — and even included the use of the saline method for second trimester abortion care, an outdated procedure that is unnecessarily difficult for patients to endure and has been replaced, long ago, in the patient-focused, abortion clinic setting with a surgical alternative, Dilation and Evacuation, or D&E.

Residents at New York University's Ob/Gyn program reported that abortion was not part of the required curriculum and that all terminations were performed in the operating room. Residents explained that it was almost impossible to get trained in second trimester procedures since attending physicians were not willing to

perform this procedure. A follow-up interview with an Ob/Gyn clinic director at Bellevue Hospital, a New York City public hospital where NYU residents rotate for training, found that while abortions were being performed in the outpatient clinic, there was no training occurring at the site. Bellevue was in need of attending physicians who could perform all abortion procedures, particularly the Dilation and Evacuation method, to train residents.

With the exception of a few programs that had established ambulatory-based abortion services, many residents reported that training was only available through the operating room, which limited the amount of procedures available for training.

Several residents expressed frustration that ambulatory-based abortion services were available at their sites but they had no access to training in that setting.

The results of these interviews were released in our “Resident Report” which helped substantiate the training problems encountered in New York City hospitals.

The Residency Training Initiative Director then arranged meetings with residency directors around New York City to investigate if there was interest in improving services and training. Meeting after meeting the staff heard every possible reason, ranging from lack of resources to hostile hospital climates, to bold contradictions of what had been reported directly by residents, for why improving abortion training was not possible (or necessary). Several committed physicians reminisced over their failed attempts to improve services, while one hostile physician began the meeting by dumping NARAL/NY’s Residency Report in her office trash can. We had little leverage to influence improvements and relied upon physicians’ willingness to “do the right thing.” Even the staunchest pro-choice ally within the hospital hierarchy could do little but smile, pat our heads and send us on our way. From across every

desk we heard the same message just in different ways: “The hospital won’t go for it,” “my residents are too busy as it is,” “we’re doing the best we can,” “if you think that’s bad, check out the contraceptive training,” “I’ve tried and it just can’t be done.” Every single one said “I’m pro-choice,” and several were even NARAL/NY members, though none were encouraging.

One conversation in particular with a physician at New York University Medical Center revealed to us one of the most nagging barriers to offering residents modern training. We learned that in order to expose residents to an adequate supply and range of different procedures, many residency programs affiliate with different hospitals and rotate residents through those settings. This meant that not one, but two hospital administrations were involved, and that both could cast blame on the other for inertia and unwillingness to consider integrating resident training in abortion. In New York City, many private hospital sponsored Ob/Gyn residency programs have affiliated with the New York City public hospitals so that residents can obtain hands-on training in many procedures. It provides the public hospitals with much needed staffing, and residents with an abundant supply of training opportunities. Eight of the New York City public hospitals, which are managed and operated by the Health and Hospitals Corporation (HHC), train residents from many prestigious programs, such as New York University Medical Center, Mount Sinai, and Albert Einstein. One problem that arises with some of these arrangements is that the public hospital setting is reliant on public funds to support its operations and modernizations are often slow and mired in bureaucracy.

The physician faculty is charged with providing residents with the most up-to-date training in often out-of-date settings.

We looked more closely at the residency programs rotating through the HHC hospitals and found that these were the sites where residents experienced the most frustration in accessing abortion training even though, unlike other non-public teaching hospitals, the city-run facilities provided a high volume of abortion services. In fact, the 11 city public hospitals provided more abortion services than the 35 New York City voluntary hospitals combined.

Over 150 Ob/Gyn doctors are trained through HHC each year, but few were leaving prepared to offer patients comprehensive abortion care.

We began meeting with abortion providers within each of the eight public hospitals that educate Ob/Gyn residents and learned that many had attempted to improve the service, and several were hired for that expressed purpose. The massive, and slow-moving bureaucracy of the HHC hospital system, however, had stalled their efforts. Many also explained that the hospital administrations were conservative and recalled being told that to even improve and bring abortion care up-to-date was tantamount to “promoting” abortion. A facilities manager at Kings County explained that in the ten years he had worked at the facility every medical service had been upgraded, except the abortion service which happened to be the most common ambulatory surgery the hospital offered.

Most disturbing was the institutional neglect of the abortion service:

- **Several facilities subjected patients to extreme delays (in some cases as long as three weeks) and numerous appointments before obtaining a procedure — forcing many into the later stages of pregnancy when a procedure becomes more complicated, riskier and costly.**

- **More mild and safe pain management methods that are the standard at freestanding clinics and private practice-based abortion services were not available for patients or for resident training opportunities.**
- **The earliest methods of abortion care, such as medical abortion and manual vacuum aspiration, were also not available because the hospital-based procedure is almost always located in the operating room—a valuable surgical space not appropriate for prescribed, early or simpler methods.**
- **With the exception of the abortion providers, the abortion services rarely had dedicated staff, and as a result, providers relied on an inconsistent array of personnel, many of whom were uncomfortable in taking part in abortion care. One provider described what had for him become a common experience: after providing a tubal ligation for one patient, the operating room staff left to be replaced by a new staff willing to help him provide an abortion for the next scheduled patient.**
- **One HHC hospital only offered abortion services on Saturdays, when residents were not at the facility (this was a practice held over—for no apparent reason— from when the residency was sponsored by a Catholic program).**
- **At another facility residents rotated only through “Building A” but the abortion procedures took place in “Building D” — This not only removed abortion services from the regular Gyn resident rotation, resulting in zero resident participation, but led to a dangerous situation that if complication should arise, the abortion patient would need to be taken by gurney onto the street and rushed three buildings down to where the nearest operating room was located.**

The abortion services being offered to poor women throughout much of HHC were clearly substandard, and the ways in which the abortion service was disconnected from training was countless and, in some cases, absurd. While this situation transpired, ironically, most residents indicated that they wanted to be trained and hoped to offer abortion care to future patients. We knew this because we followed up our “Resident Report” with a formal survey that was distributed in New York State’s Ob/Gyn programs. The results revealed that 61.8% of responding residents in New York wanted to offer abortion services to patients.

Finally, because of the confusing language handed down by the ACGME regarding abortion training, some residency directors deemphasized the importance of abortion training (knowing that the program’s accreditation was not at stake by not providing this training) and opted instead to expose residents only to procedures with stringent academic requirements. The New York State Hospital Code limits the working hours of physicians in hospital residency training programs to no more than 80 hours per week over a four-week period and no more than 24 consecutive hours. The result: residents were not expected to routinely learn one of the most common gynecological procedures needed by American women.

Because the abortion service was voluminous, but unacknowledged, throughout HHC, we also discovered that many facilities were not being reimbursed for much of the care they provided. The mission of the New York City public hospitals is “to extend equally to all we serve comprehensive health services.” HHC cares for the poorest of New York City residents regardless of their ability to pay and, as a result, absorbs the costs of many of its services. However, New York State is one of only 18 states that cover abortion under Medicaid. Many women can obtain temporary Medicaid coverage for elective abortion care, but only if the hospital efficiently processes a woman’s Medicaid application. With a little research, we found that throughout HHC’s facilities abortion was the highest non-reimbursed service of all medical procedures. Patients were not being enrolled for the benefits to which they were entitled and the

facilities were literally paying for that mistake. We determined that most facilities were offering abortion services in an operating room setting rather than an ambulatory setting. This arrangement cost HHC hospitals millions of dollars each year. With a simple change of location, moving the abortion service out of the operating room setting and into a procedure room, each facility would be reimbursed for the service at the same rate as it would were it offered in the operating room. The procedure would involve fewer staff and circumvent the use of expensive surgical space.

By moving the procedure out of the operating room each facility would be able to care for more patients each day, eliminate patient delays, and provide the care in a more cost-efficient way.

The providers within each facility became our “medical advisors” with whom we crafted a recommendation report entitled: ***Improving Residency Training in Abortion by Improving the Delivery of Services at HHC Hospitals***. The report contained five ways to improving resident training:

- Relocate abortion services, when appropriate, from operating rooms to procedure rooms;
- Integrate more modern and early methods of abortion;
- Include mandatory training in abortion for residents without objections into contract negotiations with sponsoring programs;
- Provide abortion training where residents currently rotate;
- Host mandatory continuing medical education trainings for attending physicians in modern and medically preferred abortion methods.

step two:

implementing a strategy and organizing community leaders

We devised a plan for which there was only a small window of opportunity. If a bold step forward in remedying the provider shortage were to happen, New York City was the most appropriate place. If there were a public hospital system most in need of improvements, one that trained the most Ob/Gyn residents, and whose patients turned to its sites for this care, it was New York City's HHC.

If there were an election in which all candidates were, and wanted to prove they were pro-choice, it was the 2001 New York City mayoral race.

The Residency Training Initiative staff had been recruiting community leaders in New York who wanted to use their leadership positions to leverage broad institutional commitment to the improvement of abortion services and training throughout HHC. Fifteen women and men, well known in politics, health care, women's rights and philanthropy, comprised our new "Residency Training Initiative Committee."

In February of 2001, with our recommendation report in hand, we convened our new Residency Training Initiative Committee, briefed them on our findings and our plan.

The mayor of New York City has substantial influence over the direction of the Health and Hospitals Corporation, the private corporation that oversees the management of the City's

public hospitals. The mayor appoints 15 out of 16 members of the HHC Board of Directors, with the 16th member chosen by the appointed 15. The mayor approves the budget for HHC and appoints its president.

The mayor of New York City, we determined, could set in motion a pro-choice action that would not only help women of the city now, but would also ensure that women throughout the country would have safe abortion services for generations to come.

The Residency Training Initiative staff helped the committee work on a detailed briefing for all of the mayoral candidates. Over the summer of 2001, we met with each mayoral candidate and explained the effect this initiative could have on the national abortion provider shortage, the clinical benefits it offered to patients of HHC, and the financial advantages to improving the delivery of care at each site. Each candidate listened thoughtfully and agreed to the plan. It was an initiative each promised to implement if elected. Then-candidate Michael Bloomberg, who was also at the time Board Chair of Johns Hopkins Medical School, went so far as to interview the chief resident and staff at Johns Hopkins about the availability of abortion training, and the medical appropriateness of our recommendations. During the mayoral campaign, he included our recommendations as part of his campaign proposal, "A Blueprint for Public Health."

After the election we feared that our proposal, along with many other beneficial initiatives planned for the city, might be lost in the ensuing trauma the city was struggling under after the September 11th disaster. It was at this time that a reporter from the *Village Voice* called to learn more about the resident training initiative that Mayor Bloomberg put forth in his "Blueprint."

step three:

media underscores the importance of our mission and motivates others

Four days after his inauguration the *Village Voice* ran a story with the headline: “Mayor’s Choice: Bloomberg Backs Bold New Abortion Training Plan” and went on to report, “Buried in one of Mike Bloomberg’s campaign documents is a bold plan: to make abortion a standard part of Ob/Gyn instruction in the city’s hospitals. Because his election seemed so improbable, Bloomberg’s ‘Blueprint for Public Health’ barely made a ripple — let alone a splash—when it was first unveiled.

“But should the new mayor make good on the document’s controversial promise, the results will be groundbreaking.”

The article continued, “No other city is known to have institutionalized abortion training in its public hospitals. Jubilant pro-choice advocates say the move would not only improve services for the city’s uninsured women but will also help alleviate a shortage of abortion providers nationwide.”

We *were* jubilant. Mayor Bloomberg’s staff confirmed his intentions to implement our plan. This first news story also sparked interest from other media outlets and newspapers. For seven months, there was not a week without coverage of Bloomberg’s residency training plan, from *The New York Times*, to *The Chicago Tribune*, to local news stations from around the country, and medical journals. Our office buzzed with interest and inquiries as to how to replicate this initiative elsewhere. *The Washington Post* editorialized in support of Bloomberg’s plan saying: “In short, no one should assume that the provider shortage has gone away. If anything, RU 486, and the response to it, point out the need for doctors comfortable with the abortion procedure. Proponents should keep looking for ways to produce them: a good model is New York Mayor Michael Bloomberg’s move to require abortion training as part of Ob/Gyn residencies in

the city’s public hospitals. More than a new pill, this initiative gets to the root of the shortage: a generation of doctors who have not seen the effects of illegal abortion and who often find training is unavailable, non-mandatory or inconvenient. Under the Bloomberg plan there will be a conscience clause for residents who don’t want to do abortion, as there should be. But this initiative, if brought to bear elsewhere, might help produce a generation of doctors qualified to provide abortion, surgical and medical, ably and safely.”

step four:

helping provide resources for needed changes

With the help of the newly-elected New York City Public Advocate, Betsy Gotbaum, we met with the administration and new president of the Health and Hospitals Corporation to discuss next steps. We linked the medical director of HHC with our “medical advisors” as well as nationally recognized abortion training experts, and private foundation funding. We recognized that still more funding would be needed for each facility to make site improvements and lobbied the New York City Council to allocate funds for the facility most in need of immediate improvements. On July 7, 2002, top administrators at HHC sent a memorandum to all of its residency directors and department chairs stating that routine and modern abortion training would be expected for residents without objections. Residents were surveyed on their plans to participate: 86% would. Most surprising, residents from the one Catholic residency program, New York Medical College, who rotate through HHC’s Metropolitan Hospital, sent back their surveys too: 100% wanted to be trained in abortion care.

Our “medical advisors” formed a working group with senior administrators within HHC to focus on service delivery improvements and the integration of residents into a modern abortion unit. In the winter of 2002, a daylong mandatory Continuing Medical Education will be hosted for all attending faculty and residents to attend. HHC cancelled all elective surgeries for that day to assure that most could participate.

a local approach takes off nationally

The staff of the Residency Training Initiative will continue to monitor the progress of the HHC training initiative with the help of the New York City Public Advocate, residents and with our medical advisors. We have also found that this success has awakened interest in others. Advocates, elected officials and physicians from around the country have called our offices for guidance and support that we enthusiastically provide. Our goal is to copy this local approach elsewhere. And, again, as serendipity would have it, our research has revealed that the progressive, and pro-choice, urban centers of our country are home to most of our nation's academic medical centers. It is there, working alongside local reproductive rights advocates, we hope to find again a few wearied but unbowed pro-choice physicians willing to take a chance on a small staff with a big plan.

The New York City Public Hospital success will result in over 150 Ob/Gyn physicians being trained each year to offer quality, safe and modern abortion services. Within the New York City Public Hospitals, indigent women will now have access to efficient, earlier and modern abortion services equal in quality to services offered to women of means. The New York City Public Hospitals will retain more women patients and cut costs by offering better services.

Over the course of this effort, we learned many important lessons. First, we learned, or rather were reminded, that advocates do not need to be medical professionals to work to improve health services for women. In fact, physicians need advocates to employ our unique strengths, political influence, and relationships with pro-choice supporters and community leaders to leverage this type of institutional change. Most of our physician advisors struggled to secure improvements from the massive hospital bureaucracies for a service that many administrators traditionally ignored. It was not until the Residency Training Initiative staff brought the physicians together did we recognize how systemic the problem was, how great the potential for change was, and that we were stronger when working as a team. This one large public effort achieved more than a hundred small, isolated, internal efforts ever could. We could not have been successful without the leadership and commitment of

the physicians within the public hospitals, a truly pro-choice Mayor, and a dedicated group of senior administrators within HHC who, along with our physician advisors, are doing the most important work to put improvements in place. The physicians' willingness to believe, however improbable it may have at first seemed, that institutional change could happen by partnering with advocates was the firm foundation on which this victory was won.

We look forward to the day when abortion is an integrated part of mainstream medical care, when physicians who provide this service do so as part of their overall practice to women patients, and when residents who want abortion training are not stigmatized by their peers. We believe this project is an important component in achieving that goal, and in creating the next generation of physicians willing to provide abortion services.

Ahead, we look to implementing this success in other municipalities and states. Perhaps the most important lesson from this work is that in order to be successful, advocates and physicians must work together and respect the integral role that each plays in achieving these kinds of successes. Across the country advocates have focused in recent years primarily on legislative and electoral goals, while physicians and other providers have concentrated primarily on providing the best patient care possible. But we will only meet this challenge of creating the next generation of providers by working together and embracing each other's strengths.

When Margaret Sanger and her contemporaries set about changing the world by offering women birth control and with it, finally, a way to control their reproductive destiny, they did not view the daunting challenges before them in terms of proscribed roles. They invented a movement of providers and advocates marching hand-in-hand, doing whatever success required.

In the present day it is important to revisit that model. It is now our responsibility to carry the torch of reproductive freedom for the lives of women and girls who come after us. By working together for the common goal of training the future generation of providers, success is not only probable, it is inevitable.

endnotes

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