



Association of Reproductive Health Training on Intention to Provide Services After Residency:

The Family Physician Resident Survey

Diana Romero, PhD, MA; Lisa Maldonado, MA, MPH; Liza Fuentes, MPH; Linda Prine, MD

BACKGROUND AND OBJECTIVES: High rates of unintended pregnancy and need for reproductive health services (RHS), including abortion, require continued efforts to train medical professionals and increase availability of these services. With US approval 12 years ago of Mifepristone, a medication abortion pill, abortion services are additionally amenable to primary care. Family physicians are a logical group to focus on given that they provide the bulk of primary care.

METHODS: We analyzed data from an annual survey (2007–2010) of third-year family medicine residents (n=284, response rate=48%–64%) in programs offering abortion training to examine the association between such training and self-reported competence and intentions to provide RHS (with a particular focus on abortion) upon graduation from residency.

RESULTS: The majority of residents (75% in most cases) were trained in each of the RHS we asked about; relatively fewer trained in implant insertion (39%), electric vacuum aspiration (EVA) (58%), and manual vacuum aspiration (MVA) (69%). Perceived competence on the part of the graduating residents ranged from high levels in pregnancy options counseling (89%) and IUD insertion (85%) to lows in ultrasound and EVA (both 34%). Bivariate analysis revealed significant associations between number of procedures performed and future intentions to provide them. The association between competence and intentions persisted for all procedures in multivariate analysis, adjusting for number of procedures. Further, the total number of abortions performed during residency increased the odds of intending to provide MVA and medication abortion by 3% and 2%, respectively.

CONCLUSIONS: Findings support augmenting training in RHS for family medicine residents, given that almost half (45%) of those trained intended to provide abortions. The volume of training should be increased so more residents feel competent, particularly in light of the fact that combined exposure to different abortion procedures has a cumulative impact on intention to provide MVA and medication abortion.

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The widespread need in the United States for reproductive health services has been clearly documented.¹ Improved family planning services to better space pregnancies and decrease unintended pregnancies is one of the goals of Healthy People 2020.² That approximately half of pregnancies each year are unintended, 43% of which end in abortion,³ attests to the importance of increased availability of reproductive-related services. Given that reproductive health services are among the most commonly performed in the United States (including abortion),⁴ numerous efforts have been undertaken to increase the number of health care providers offering these services.^{5,6} Over the past decade, a concerted effort to consider physicians other than obstetrician-gynecologists (ie, family physicians)⁷⁻¹¹ and advanced practice clinicians (eg, nurse practitioners, physician assistants, and certified nurse-midwives)¹²⁻¹⁴ has been important for increasing providers of these services.

From CUNY School of Public Health, Hunter College, New York, NY (Dr Romero); Reproductive Health Access Project, New York, NY (Ms Maldonado); The Graduate Center, City University of New York (Ms Fuentes); Reproductive Health Access Project, Beth Israel Residency in Urban Family Practice, and Department of Family Medicine, Albert Einstein College of Medicine, Bronx, NY (Dr Prine).

Family physicians are an obvious group to consider since they provide the bulk of primary care in this country.¹⁵ The geographic location of family physicians mirrors the distribution of the population—77% practice in urban areas (where 79% of the population lives), and 22% practice in rural areas (where 21% of the population lives). Thus, integrating contraception and abortion into family medicine residency training has the potential of greatly expanding access to these services. There are 461 family medicine residency programs nationwide.¹⁶ In 2002, 11 of these provided abortion training as part of their core curriculum.¹⁷ Today, approximately 25 programs (5.4%) offer “opt-out” abortion training, meaning that residents will receive such training unless they explicitly elect not to (The Center for Reproductive Health Education in Family Medicine (<http://rhedi.org/resources/programs.php>). Other residency programs may allow abortion training as an elective, requiring more initiative on the part of the resident. Although these programs represent a very small fraction of the total number of family medicine residents trained annually (10,380 in 2013),¹⁶ this number may grow as more residency programs add abortion training to their curricula.

The Reproductive Health Access Project (RHAP) is a nonprofit organization in New York City that provides training and technical assistance to primary care clinicians and health care organizations across the United States in order to expand access to contraceptive and abortion care. RHAP conducts an annual survey of graduating family medicine residents trained in abortion to identify graduates in need of more training or technical assistance. We analyzed data from RHAP’s annual family medicine resident surveys from 2007 to 2010 to understand the association of abortion training during residency with intention to provide abortion care after residency, including identification of factors associated with intending

to provide abortion (eg, geographic location, amount/type of training received, practice setting, other family planning services provided), and identification of actual or perceived barriers to providing abortion care after residency.

Methods

Sample

Each year from 2007 to 2010, third-year residents graduating from family medicine residency programs that include abortion training in their curricula were invited to take a confidential survey administered using the online tool SurveyMonkey® (Palo Alto, CA). RHAP worked with the residency training coordinators to verify names, email, and mailing addresses for all residents attending family medicine residencies providing abortion training. In addition, sites offering “elective” abortion training to residents were asked to either provide contact information on any family medicine residents who rotated through their program so that they could be invited directly to participate in the survey or forward a link to the online survey to family medicine residents who had rotated through their site. RHAP also utilized an online listserv created by the Society of Teachers of Family Medicine’s Group on Abortion Training and Access to reach graduating residents who received training. The survey was administered between April and June each year, to coincide with the time period when third-year residents were completing their residencies and able to respond to questions about their training and post-residency plans. For this 4-year sample, the overwhelming majority of respondents were from the targeted residency programs. This research was approved by the Institutional Review Board of the Institute of Family Health in New York, NY (Protocol #508).

Data

The content of the survey was informed by focus groups that RHAP conducted with family medicine

faculty and recently graduated family physicians. The surveys consisted of approximately 50 closed-ended questions that collected data across three domains: training, competence, and intentions to provide RHS; type of practice intended after residency, and barriers anticipated to providing abortion services. Specific questions used in the analysis are summarized below according to domain.

Training, competence, and plans to provide abortion and other RHS: For each of 11 reproductive health-related procedures, residents were asked whether they had received training, felt competent in the skill, number of each procedure performed during residency, and whether they planned to provide the procedure after residency. (A non-reproductive health procedure, incision and drainage of abscess, was included to gauge the presence of general procedural training in the residencies.)

Post-residency plans: Residents were asked to describe their future practice setting (including geographical location) such as: fellowship, academic position, abortion and/or family planning clinic, private practice, and community health center.

Barriers to providing abortion: Respondents who reported that they did not plan to provide abortion services after residency were asked why, such as: didn’t get enough training, it’s too controversial, won’t see women of reproductive age in new job; “other” responses were re-coded into six additional categories.

Analytic Strategy

For each of the reproductive health-related procedures, univariate analyses involved calculation of the proportion of residents reporting being trained in the procedure, feeling competent, and intending to perform it after residency. Additionally, we calculated the mean and median number of procedures performed and the proportion who felt competent among those who were trained in each procedure. Finally, the proportion of this group (ie, trained and felt competent) who intended to provide

the procedure after residency was determined.

Bivariate and multivariate analyses were conducted to determine which factors were associated with residents' intentions to provide abortion care and other reproductive health-related procedures. Pearson's chi-square tests were performed to identify relationships between feeling competent in a procedure and planning to provide it. *T* tests were performed to test whether those who planned to provide a procedure had performed a significantly higher mean number during residency. As the distribution of the variables was not normal, Mann-Whitney U tests were also performed, which produced similar results.

Finally, logistic regression was used to determine the odds of intending to provide a procedure taking into account (1) whether the resident felt competent in the procedure and (2) the number of procedures performed during residency.

Results

Sample Description

A total of 284 residents in 35 family medicine residency programs responded to the 2007–2010 surveys (response rates: 48%–64%). (As described in the Introduction, PGY-3 family medicine residents receiving additional training in abortion care are variously located in programs across the country; thus, any approaches used to recruit them into a study are unlikely to reach the complete universe. In this study, success in reaching residents in these programs and the accompanying response rates [RR] improved dramatically after the first year [2007] of the study. As such, we report a range for the RR, from 64% [for years 2008–2010] to a more conservative 48% that includes the 2007 sample by imputing the sampling frame [ie, denominator] from the mean sampling frame of the subsequent 3 years). We grouped them by the four US Census Bureau regions, and the distribution was as

follows: 52% were in residencies in the Northeast, 43% were in the West, and 5% were in the Midwest. No respondents reported training programs in the South.

With regard to training, the majority of residents (about 75% in most cases) reported having been trained in the 13 procedures (Table 1). The few exceptions included progestin implant insertion, for which only 39% of residents were trained, followed by EVA (electrical vacuum aspiration) (58%), and MVA (manual vacuum aspiration) (69%). The procedure with the highest training prevalence was abscess incision and drainage (82%). The next analysis focused on competence in procedures among those who were trained in the procedure (Table 2). Reported competence ranged from high levels in pregnancy options counseling (88%) and IUD insertion (85%), to low levels in ultrasound and EVA (both 34%). The majority of those who were both trained in and felt competent to provide each

Table 1: Frequency of Procedure Training, Mean Number, and Range of Procedures Performed in Residency

Procedure	% Trained in Procedure (n)	Mean Number of Procedures Performed (SD)	Range of Number of Procedures Performed
Patient education and referral			
Pregnancy options counseling	78.5 (223)	35.9 (46.4)	0–300
Abortion referrals	74.6 (212)	7.3 (8.9)	0–50
Contraception			
IUD insertion	77.1 (219)	18.1 (16.8)	0–100
Implanon insertion	39.3 (101)	1.8 (3.1)	0–20
Abortion			
Medication abortion	71.1 (202)	9.3 (13.2)	0–80
Manual vacuum aspiration	69.0 (196)	17.5 (22.3)	0–100
Electric vacuum aspiration	57.7 (164)	9.8 (14.6)	0–80
Post-abortion care	70.1 (199)	16.0 (25.5)	0–150
Other gynecology and family medicine			
Ultrasound	77.8 (221)	26.5 (26.3)	0–100
Miscarriage management	77.5 (220)	9.0 (10.5)	0–60
Abscess incision and drainage	82.0 (100)	14.5 (14.2)	0–100
Endometrial biopsy	76.2 (93)	*	*
Lumbar puncture	*	5.0 (6.5)	0–50

* Data not collected for number of endometrial biopsy procedures and training in lumbar puncture

Table 2: Self-Reported Competence and Intention to Provide Reproductive Health Procedures Among Residents Who Received Training

Procedure	% Who Feel Competent (n)	% Who Intend to Provide Among Those Who Feel Competent (n)
Patient education and referral		
Pregnancy options counseling	88.3 (197)	89.8 (177)
Abortion referral	79.9 (159)	95 (151)
Contraception		
IUD insertion	84.5 (185)	94.1 (174)
Implanon insertion	41.6 (42)	85.7 (36)
Abortion		
Medication abortion	53.5 (108)	72.2 (78)
Manual vacuum aspiration (MVA)	46.9 (92)	65.2 (60)
Electric vacuum aspiration (EVA)	34.1 (56)	65.4 (34)
Post-abortion care	62.8 (125)	79.2 (99)
Other gynecology and family medicine		
Ultrasound	33.9 (75)	70.7 (53)
Miscarriage management	64.1 (141)	82.3 (116)
Abscess incision and drainage	80 (80)	85.0 (68)
Endometrial biopsy	62.4 (58)	91.4 (53)

procedure, indeed, planned to provide the procedure in their post-residency practice (range: 65%–95%) (Table 2). The procedures with the lowest proportion of residents who intended to provide them after residency were EVA and MVA (both 65%), ultrasound (71%), and medication abortion (72%). When specifically considering residents trained in abortion, 45% intended to provide all three types of procedures.

Bivariate and Multivariate Analyses

Pearson chi-square tests of the relationship between feeling competent in a procedure and planning to provide it were all significant at the $P \leq .001$ level (data not shown). *T* tests were conducted to determine if the mean number of procedures performed during residency differed between those who intended and did not intend to provide each

procedure (Table 3). (Because the procedure variables were not normally distributed, we also performed Mann-Whitney U tests on the median values to test the bivariate associations. Statistics for both tests gave consistent *P* values below .05 for all associations tested.) For all but two procedures, those who intended to provide them after residency had performed a higher mean number of procedures during residency compared with those who did not intend to provide the procedures. The only procedures in which the association was not statistically significant were pregnancy options counseling and abscess incision and drainage. For seven of the 11 procedures, higher rates of performance during residency were associated with greater likelihood of intention to provide the service after residency. (Multivariate analysis could not be carried out for two [endometrial biopsy and

lumbar puncture] of the total 13 procedures, as data were not collected for the number of those procedures performed. Specifically, compared to residents not intending to provide the service after residency, the mean number performed by residents intending to provide the service ranged between two and three times higher.)

Considering that the bivariate analyses revealed significant associations between intention to provide the service and both reported competence in a procedure and number of procedures performed, we included those variables in the multivariate analysis. Model 1 regressed intention to provide each procedure on reported competence in the procedure. Model 2 added the number of procedures performed. Model 3 was limited to the three abortion procedures and regressed intention to provide each respective abortion procedure on the total number of abortion procedures (ie, MVA, EVA, and medication abortion) performed (Table 4). We posited that in addition to potentially increasing one's medical skill in the procedures, cumulative experience providing abortion might increase residents' intentions to provide any kind of abortion procedure.

Consistent with the bivariate findings, the results for Model 1 demonstrated a significant association between competence and intention to perform each of the procedures. In Model 2, after adjusting for number of procedures performed, the association between competence and intention persisted for all procedures; however, for nine of the procedures, the number of procedures performed was not significantly associated with the intention to provide it. The two exceptions included ultrasound and MVA, wherein having performed more procedures was associated with a higher probability of intending to provide them over and above perceived competence. For every additional ultrasound performed, residents had a 3% higher odds of intending to provide it; the same was true of MVAs. The results for Model 3 (ie, for the three abortion-specific

Table 3: Mean and Median # of Procedures Performed by Trained Residents Among Those Intending to Provide Versus Those Not Intending to Provide After Residency

Procedure	Mean # Performed		Median # Performed	
	Intend	Do Not Intend	Intend	Do Not Intend
Patient education and referral				
Pregnancy options counseling	36.7	32.9	25	15
Abortion referrals	8.8*	3.1	5†	3
Contraception				
IUD insertion	19.6*	13.7	17.5†	4.5
Implanon insertion	3.6*	0.7	2†	0
Abortion				
Ultrasound	42.4*	19.8	30†	12.5
Medication abortion	15.2*	6.5	10†	2
Manual vacuum aspiration	33.0*	10.1	27.5†	2
Electric vacuum aspiration	20.7*	6.6	10†	2
Other pregnancy related				
Post-abortion care	21.8*	10.2	10†	4
Miscarriage management	11.5*	5.3	8†	3
Other gynecology and family medicine				
Abscess incision and drainage	15.1	12.3	10	10

* *t* test *P* value $\leq .05$ † Mann-Whitney *U* test *P* value $\leq .05$

procedures) indicate that the total number of abortions performed during residency increased the odds of intending to provide both MVA and medication abortion by 3% and 2%, respectively. However, the total number of abortions performed was not associated with an increased likelihood of intending to provide EVA after residency. (An additional analysis was conducted for the three procedures [ultrasound, MVA, and medication abortion [MA] that demonstrated a relationship between number performed and intention to provide [after adjusting for self-assessed competence]. For each procedure, we separated the residents into quartiles according to the number of procedures performed during residency training [using total number of abortions for the MVA and MA analyses] and re-ran the logistic regression. The findings were consistent for all three procedures, in that there were significantly more residents in the higher quartiles [ie,

they did more procedures] among those who intended to perform the service compared to more residents in the lower quartiles [ie, they did fewer procedures] among those who did not intend to provide the service. Put another way, each higher quartile was associated with significantly greater odds of intending to provide the procedure.)

Finally, among residents who did not intend to provide abortion care after residency, several reasons were given. Need for more training was most common (28%), followed by the likelihood that their future practice setting would not allow it (16%), its inconsistency with their religious or other belief system (15%), its controversial nature (8%), and being interested in other medical areas (7%).

Discussion

Results from this national sample of family medicine residents who received training in abortion and other RHS demonstrate a consistently

strong relationship between number of procedures performed, perceived competence, and intentions to provide RHS after residency. These findings are consistent with previous, smaller-scale studies of family medicine residents documenting an association between perceived competence and intention to provide specific clinical services in future practice.^{7,8,10} Our analyses went further, documenting a dose-response relationship between the total number of abortion procedures performed and intention to specifically provide MVA and medication abortion. The lack of a dose-response relationship with EVA may be due to factors in addition to the relatively less training received. Specifically, EVAs require additional equipment. They are generally performed in settings where a high volume of abortion care is provided and are, therefore, less likely to be offered in primary care settings.

Table 4: Logistic Regression of Intention to Provide Specific Procedures After Residency (Among Trained) Considering Self-Assessment of Competence and Number of Procedures Performed During Residency

	Odds Ratio		
	Model 1 (95% CI)	Model 2 (95% CI)	Model 3 (95% CI)
Patient education and counseling			
Pregnancy options counseling			
Felt competent	16.3* (4.1–63.9)	16.44* (4.2–65.0)	—
# pregnancy options counseling		1.00 (.988–1.02)	
Abortion referrals			
Felt competent	32.7* (8.1–131.7)	25.6* (6.0–109.1)	—
# abortion referrals		1.0 (.93–1.2)	
Contraception			
IUD insertion			
Felt competent	41.0* (10.6–158.9)	71.4* (14.4–352.2)	—
# IUD insertions		.97 (.94–1.0)	
Implanon insertion			
Felt competent	9.7* (2.8–33.0)	5.4* (1.4–21.4)	—
# Implanon insertions		1.2 (.91–1.7)	
Abortion			
MVA			
Felt competent	10.2* (3.4–30.9)	7.2* (2.3–23.1)	—
# MVAs		1.03* (1.001–1.06)	
MVA			
Felt competent	10.2* (3.2–32.3)		5.5* (1.5–19.5)
Total # abortions			1.03* (1.008–1.05)
EVA			
Felt competent	7.8* (2.3–26.4)	6.4* (1.8–22.4)	—
# EVAs		1.0 (.98–1.1)	
EVA			
Felt competent	7.1* (2.1–24.3)		5.4* (1.5–19.4)
Total # abortions			1.0 (.996–1.0)
Medication abortion			
Felt competent	22.8* (6.4–80.7)	20.1* (5.4–75.7)	
# Medication abortions		1.0 (.96–1.1)	—
Medication abortion			
Felt competent	26.8* (7.0–102.1)		20.5* (5.1–82.6)
Total # abortions			1.02* (1.001–1.045)
Post-abortion care			
Felt competent	8.9* (3.0–26.2)	8.6* (2.9–25.4)	—
# post-abortion care		1.0 (.98–1.0)	

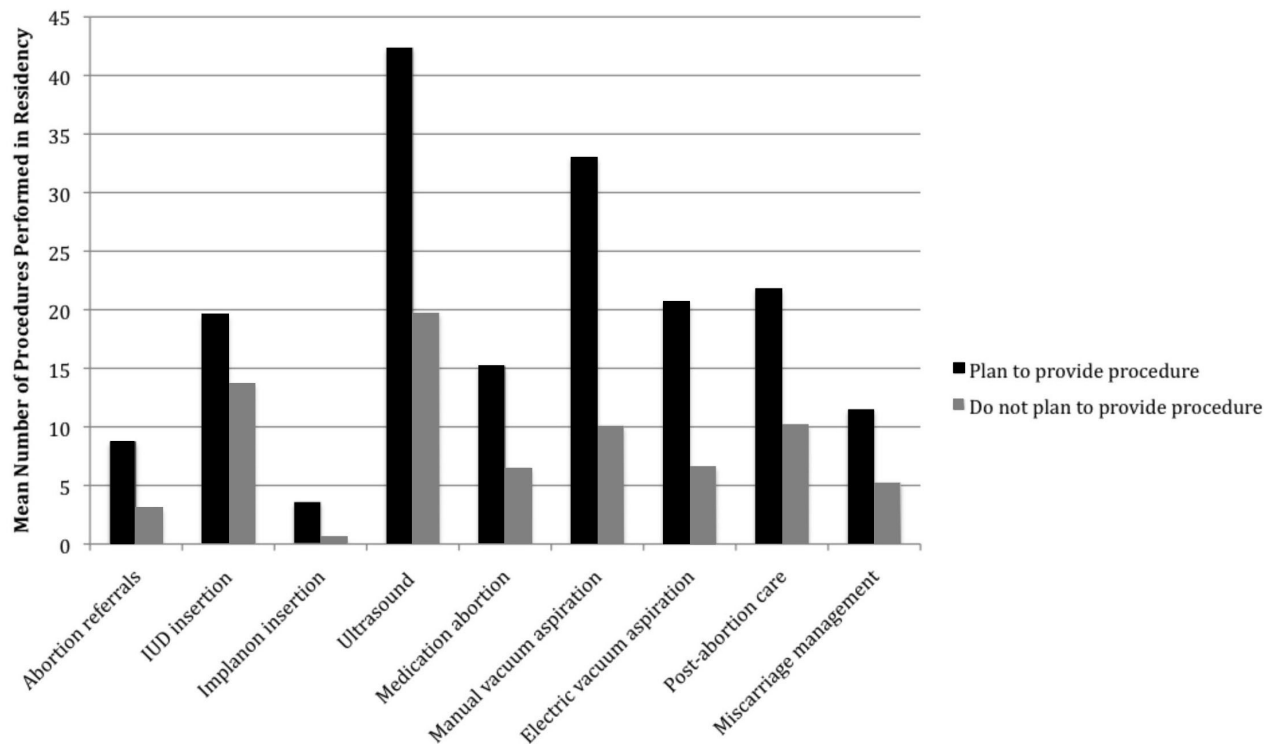
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Table 4: Continued

	Odds Ratio		
	Model 1 (95% CI)	Model 2 (95% CI)	Model 3 (95% CI)
Other gynecology and family medicine			
Miscarriage management			
Felt competent	11.4* (4.1–31.9)	9.3* (3.2–27.5)	—
# miscarriage management		1.03 (.97–1.1)	
Ultrasound			
Felt competent	7.8* (2.8–22.1)	4.9* (1.6–15.0)	—
# ultrasounds		1.03* (1.002–1.05)	
Abscess incision and drainage			
Felt competent	7.2* (2.4–21.7)	6.9* (2.2–21.7)	—
# abscess incision and drainage		1.0 (.96–1.0)	

* $P < .05$; — denotes not part of Model 3 analysis

Figure 1: Comparison of Mean Number of Procedures Performed During Residency by Post-Residency Intentions*



* Procedures included in figure are those for which significant differences exist at the $P < .05$ level.

The association between the number of procedures performed during residency and intention to provide differed by the level of complexity involved, such that residents' number of "non-procedure services" performed (eg, pregnancy options counseling and abortion referral) did

not predict intention to provide them after adjusting for competence. As expected, less experience with non-procedure services might not impede intentions to provide them because competence can be achieved with relatively little experience. For example, a resident who provided pregnancy

options counseling two to three times might feel competent and intend to provide this service in his/her practice. At the other extreme, more complex procedures (eg, MVA and medication abortion) requiring more practice to achieve competency had the strongest association between

the number of procedures performed and future intentions (Figure 1).

Given the potentially different contexts under which pregnancy termination occurs, the finding that opportunities to perform multiple methods of abortion may increase a clinician's intention to provide either medication abortion or MVA is encouraging. The potential impact of these findings is uncertain with regard to family physicians' scope of practice. While several documents address scope of practice in family medicine, a definitive position regarding provision of abortion services and resident training is lacking. The ACGME Program Requirements for Graduate Medical Education in Family Medicine include specific training requirements for family planning, contraception, and pregnancy options counseling but do not address training related to abortion or management of early pregnancy loss.¹⁸ The most recent educational guidelines on maternity and gynecologic care from the American Academy of Family Physicians (AAFP), which were revised in September 2012, indicate that "dilation and curettage for incomplete abortion" be a core skill of educational curricula.¹⁹ Neither document addresses the role of medication management of abortion; however, a position on its important role within the scope of family medicine was published separately.²⁰ Finally, a consensus statement was issued several years ago by the Society of Teachers of Family Medicine Group on Hospital Medicine and Procedural Training, which included "uterine aspiration/dilation and curettage" as a core procedure that all residents be exposed to and train to independent performance.²¹

One strength of this study is the large sample, given that in any one year there is a fairly small cohort of family medicine residents nationally that has the option to receive full spectrum training in reproductive health. Thus, the combined 2007–2010 dataset permitted multivariate analyses to identify predictors of intention to provide services, which

had not been carried out in previous related studies.^{7,8,10} Further, this analysis operationalized experience with provision of abortion both by specific procedure as well as by total number performed, which allowed us to distinguish differences in intentions that may pertain to the technical nature of the procedure from more general "exposure" of residents to patients receiving abortion services. This is particularly important as the limited findings from other research that has documented a positive association between number of abortion procedures performed and intentions to provide the service has been among OB-GYN residents, not family physicians.⁵

One potential limitation is that the number of family medicine residency programs offering family planning training changes every year. While every attempt was made to identify these programs and include them in sample recruitment, an exact denominator for the population is elusive. There is the potential for participation bias, which might over-represent residents who are more interested in reproductive health and provision of such services. Given the self-report nature of the data, more respondents might report higher levels of training and competence; however, the analyses on intention to provide these services adjust for perceived competence. As such, we are able to identify statistically significant differences in intentions adjusting for both self-reported competence as well as related and, possibly, more objective measure (ie, number of procedures performed). Therefore, even in a sample that may over-represent residents who might be more favorably disposed toward RH services, we are able to carry out a robust analysis demonstrating the differential effect that competence and number of procedures performed has on one's intention to perform select RH procedures.

Another concern might be the extent to which secular and/or medical environment changes between 2007 and 2010 may have resulted in

different resident training or practice environments that might be related to the outcomes of interest—namely, assessment of their competence to provide RHS and post-residency intentions to do so. That said, although a contentious sociopolitical environment exists with respect to abortion care, we do not believe that there were any particularly noteworthy events that would have had a differential effect on resident cohorts between 2007 and 2010. Finally, the sample does not permit us to test a hypothesis of intentions to provide RHS among family medicine residents who received no reproductive health training. While a valid research question, this analysis sought to identify factors predictive of post-residency intentions to provide RHS among residents who did obtain training in this area.

Conclusions

Our findings provide support for augmenting training opportunities in reproductive health for family medicine residents. That just under half of those trained indicated that they intended to provide abortions after residency (45% specified all three abortion procedures) speaks to the success in preparing more physicians to provide an undersupplied medical service. Findings suggest, however, that the extent of training may need to be increased to produce more residents who feel competent to provide abortion and other RHS after residency. This would address the portion of family physicians who do not plan to provide these services because they do not feel competent. That our findings also demonstrate combined exposure to different abortion procedures has a cumulative, positive impact on intention to provide MVA, and medication abortion should be considered by residency training programs going forward.

As with most research, this study raises more questions. Our positive finding regarding cumulative number of abortion procedures and intentions begs the question if there is a minimum number of cases in

residency training above which family physicians would be more likely to provide such services. If so, would that provide a rationale for training only the most “committed” in low volume settings so that they receive more training? A study design comparing residents who receive abortion training with those who do not could examine whether such training is associated with, for example, increased provision of IUDs, as well as a host of other outcomes. Such a quasi-experimental design would require more resources than the single-group design used here but could likely answer some of these questions with greater confidence. That said, we are currently collecting 5-year follow-up data that will permit us to move from a focus on residents’ intentions to actual post-residency behaviors among this group.

For the portion of physicians who indicated that they would not be providing these services due to structural barriers (eg, institutional policies, lack of support within the practice), explicit efforts need to be undertaken to specifically address the “practice environment.” This requires actions at a level above and subsequent to the individual focus of residency training programs. This could involve in-service training of staff in group practices (ie, institutional level) and provision of ongoing (eg, remote) support, as consultation may be needed initially on a patient-by-patient basis. With respect to barriers due to policies (eg, faith-based hospitals) that may prohibit provision of services such as emergency contraception and/or abortion, intervention at higher structural levels are required (eg, institutional, state, and federal policy-making entities). While there are myriad groups involved in evidence-based advocacy to consider RHS similar to other health promotive and medically necessary services, family medicine professionals

can also engage in this effort. Stronger professional consensus that the complete range of RHS fits squarely within the scope of family medicine practice is needed so that individual physicians and group practices will have a solid professional basis upon which to include reproductive health care. This would enable physicians to provide appropriate and needed services to their patients, as well as add to the ranks of medical professionals in the sorely under-resourced field of reproductive health.

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CORRESPONDING AUTHOR: Address correspondence to Dr Romero, CUNY School of Public Health at Hunter College, 2180 Third Avenue, Room 542, New York, NY 10035. 212-396-7743. diana.romero@hunter.cuny.edu.

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