Introduction

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Contraception and abortion allow women to control their reproduction. The means to accomplish reproductive control have improved over the past century as the result of revolutionary social and medical advances. The subtitle of this book refers to family planning and abortion, but our primary focus is on abortion. Contraception, while still politically embattled and not universally available, is no longer in the eye of the reactionary storm in most countries. Nevertheless, integration of all aspects of contraception into medical education is incomplete.

Termination of pregnancy ranges from simple interventions – misoprostol and mifepristone and manual or electric aspiration – to surgically complex dilation and evacuation (D&E) of the uterus. Abortion education can also be seen as a series of skills of increasing complexity taught to practitioners – nurses, medical students and residents. A book about training these practitioners could focus on these medical skills, understanding the basics of the underlying science, patient eligibility criteria, the treatment of complications and pregnancy prevention, but that is not our objective here. Instead, our vision is a systems approach: Who should be trained, and how, by whom, and where should that training be accomplished? What should it include and who defines those parameters? Who is responsible for training standards and their enforcement? What systems are in place to define and regulate training mandates? What impacts do the training of various practitioners have on health policy, on the workforce and on professionals' responsibilities as educators, researchers and social change agents?

While training represents the core of our book, its context and impact, we address the education of the medical workforce in broad health and social contexts such as maternal mortality, the politics of abortion, religion and the roles of government agencies and medical organizations in determining a country's medical workforce and practices. We address creation and implementation of the research necessary to inform policy and improve women's health. We describe the communities that have been created as components of training, both locally and globally, and their impacts, interpretations of professional responsibilities versus personal conscience and considerations of economic and social justice in access to care.

We have chosen to make training of obstetricians and gynecologists (ob-gyns) our primary focus. In the USA, it was this community, its department chairs and academic leaders and the American College of Obstetricians and Gynecologists who advocated for the legalization of abortion and, later on, for passing a training mandate and supporting abortion access despite unrelenting political interference. As one of the "core specialties," ob-gyns are responsible not only for training their own residents and fellows, but also educating all medical students in reproductive health by developing the reproductive health curriculum and organizing its implementation for most medical schools. They often participate similarly in the reproductive health aspects of training general practitioners, midwives and nurses.

We divided the book into four major sections. Section I, Abortion Training: Workforce, Leadership, Social & Political Impact, addresses major areas relevant to training, policy and access. In Chapter 1, we look at the history and reforms of the field of medical education during the past century, beginning with the Flexner Report and its impact on creating a science-based education system, published more than a century ago, leading to the 2010 Global Commission's report published by the *Lancet*, "Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent

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World." We consider workforce, professionalism and leadership in the context of the medical education systems in the USA, and the role of the Fellowship in Family Planning and the Ryan Residency Training Program in achieving a systems-integrated family planning workforce aligned with the goals of the Lancet Commission.

Chapter 2 addresses maternal mortality, a long-standing global crisis, and interventions and successes in reducing maternal deaths worldwide, highlighting the role of family planning policy, safe abortion and training of the workforce. The high rate of and the failure to reduce the maternal mortality rate (MMR) in the USA is compared to the steeply falling rates of Ethiopia and Nepal, two examples of countries whose institutionalized training programs for abortion and contraception have been pivotal in improving women's health.

The history of integrated family planning education (Chapter 3) highlights the trajectory of abortion access, service, ob-gyn educational mandates and their implementation in creating a robust and vital physician workforce to train future practitioners, conduct research, promote medical culture change and advocate for family planning, as elaborated in Chapters 4, 6 and 7. Two factors played key roles: a professional training mandate including assessment of physicians' skills and overall knowledge, and a national professional effort, in the case of the USA, two private educational initiatives, to ensure implementation.

The medical community, in particular physicians, especially ob-gyns, is uniquely positioned to advocate for abortion. In the advocacy chapter (4), we recount the history, and accomplishments of the ob-gyn academic community in promoting the legalization of and access to safe abortion during the past fifty years. A unique aspect of the national education initiatives and essential for their success was the organization of a "community of practice" (Chapter 5) that fosters learning, well-being and shared expertise in clinical care, research and advocacy.

Research is vital to evidence-based practice for improved reproductive health. The Fellowship in Family Planning's (FFP) research has built evidence for clinical practice and policy development. Chapter 6 highlights two examples of the impacts of FFP: the increase in use of long-acting reversible contraception (LARC) in the USA and the availability and safety of second-trimester surgical abortion.

Chapter 7 offers a comprehensive look at the impacts of the FFP and the Ryan Residency Training Program on reproductive health in the USA and abroad. It describes the evidence these programs have created through research, the policy developments and the roles and leadership fostered. The first section of the book closes with a review of what continues to be a major topic of debate and controversy among physicians: the role of conscience in providing abortion and reproductive health care, acceptance of training and service mandates and the laws governing conscience clauses in US and global settings (Chapter 8).

Integration of Abortion into Medical Education

In Section II, Integration of Abortion into Graduate Medical Education, Chapter 9 begins with a review of family planning training in the USA, the extent to which it has been integrated into medical education, its outcomes and the challenges met. Further exploring implementation, Chapter 10 delineates steps for the establishment of training services in teaching hospitals, highlighting the history and current services of one of the earliest abortion training and research services at the University of California, San Francisco (UCSF) which became the first FFP site and has been used as a model for the Ryan Residency Training initiative.

Uterine evacuation skills are necessary not only for the termination of a pregnancy but also in cases of early pregnancy loss. Political and institutional restrictions can make a pregnancy loss service the only option to teach uterine evacuation (Chapter 11). A systems-based approach is used to integrate clinical services for pregnancy loss into the teaching hospitals' outpatient and emergency services to enhance trainees' competence in uterine evacuation and reinforce the broader applications of uterine evacuation in clinical practice.

Collaborations with community partners, described in Chapter 12, are essential and valued components for the success of teaching hospital services and training. They offer abortion and contraceptive training opportunities not available in the teaching hospital, introduce learners to

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other models of care, strengthen institutional and community partnerships, add social and political perspectives and contribute to advocacy efforts.

A special chapter is devoted to the unique challenges of providing family planning services in a Catholic hospital, obligated to follow Catholic doctrine (directives) set and enforced by Catholic bishops and hospital administration (Chapter 13). As a result, these hospitals fail to offer any abortions except under the most extreme life-threatening circumstances, and hence are not able to fulfill the ob-gyn abortion training mandate or ensure contraceptive competency for their residents. The chapter describes how training can occur through collaboration with partner institutions or clinics.

The education of medical students is a crucial factor in preparing a competent workforce, particularly in countries where students are expected to practice immediately after graduation and may not have further training in essential services like contraception and uterine evacuation. Chapter 14 offers a comprehensive review of medical student education in abortion and family planning and guidelines for implementation.

Chapter 15's focus is on the efforts of family medicine physicians in promoting training and ensuring access. Although lacking an enforceable mandate for abortion training, family physicians have been in the forefront of providing services, particularly in community clinics. They have established national initiatives, in collaboration with ob-gyn services and community clinic partners. Advanced-practice clinicians (APCs), another essential group in the medical workforce, play a pivotal role in ensuring access to family planning services in the USA and abroad. Chapter 16 describes research that demonstrates the advantages of APCs providing abortions as well as approaches to the training and education of APCs.

In Section III, Family Planning Curricular Design and Implementation, we introduce comprehensive how-to guides on educating students and residents about abortion and family planning. We begin with Chapter 17 on the key practical steps of starting a family planning clinical service in a teaching hospital and making it financially sustainable. The chapter highlights challenges and pitfalls, and outlines the steps for designing a resident family planning rotation and preparing residents for abortions, including those who chose to participate only partially in training.

Chapter 18 describes a specific curriculum to enhance clinical teaching including the larger context of abortion care, the public health implications for safe abortion, established evidence for elements of practice and the psychosocial aspects of the provider and patient interaction. Educators can use this process for curricular design, implementation of learning assessments and program evaluation.

Chapter 19 addresses defining, implementing and assessing milestones – an integral part of medical education. The FFP created milestones for its fellows, which entailed a complex process of defining clinical skills and learning outcomes and their measurement. These milestones for advanced fellow training can be adapted to the resident curriculum.

Chapter 20 concerns the integration of family planning in the education of the 154 US medical schools that, despite professional advocacy efforts, has been inconsistent, in part as a result of traditional approaches to medical education. Reforms toward competency- and outcomes-based learning offer opportunities for innovation in teaching methods, curricular content and mentorship.

While medical school faculty worked toward reproductive health-relevant education content and systems, medical students themselves formed their own advocacy body through Medical Students for Choice, described in Chapter 21. Founded at UCSF in 1993, it now supports more than 200 medical school chapters worldwide. Students advocate for curricular reform and have created an active and influential national and global community.

Simulation has become a valued tool in medical education, as shown in Chapter 22, and is particularly useful to enhance training in family planning clinical skills. Simulation promotes interactive learning, acquisition of skills and competence before the learner begins to interact with a patient. Simulation techniques include simple, inexpensive approaches such as the "Papaya Workshops," which have been used around the world to introduce first-trimester uterine evacuation, long-acting reversible contraceptives, dilation and evacuation for advanced gestations, team-based communication skills and management of emergencies, such as uterine hemorrhage.

Chapter 23 addresses an important challenge of integrated family planning resident rotations; when residents choose to "partially participate in"

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or "opt out" of some or all aspects of the family planning rotation, patient care and staff scheduling and relationships are affected. Gauging residents' personal, moral or religious perspectives while accomplishing the learning objectives mandated by the Accreditation Council for Graduate Medical Education (ACGME) and Residency Review Committees (RRCs) is a complex task for the faculty mentor. The evaluation team of the Ryan Residency Training Program conducted studies during the past twenty years to explore residents' and faculty members' experiences with partial participation.

The stigma surrounding abortion has a profound effect on everyone involved in abortion care: learners, faculty, clinic staff and the women they serve. Chapter 24 describes the impact of stigma on the work and life of family planning providers and offers approaches to relieve the burden of stigma. Special attention paid to the emotional realm of abortion work for physicians and trainees through dedicated workshops in "values clarification" and "providers share," created by one of the chapter authors, can help to counteract and reduce stigma.

Further exploring the emotional aspects of abortion training, Chapter 25 describes the emotional, social and economic contexts patients bring to their abortion experience and the importance of acknowledging them. Skills such as active listening, refraining from making assumptions and self-reflection are necessary in pregnancy options counseling. Emotional support is also essential for the entire clinic team, including staff, and physicians, and particularly the students and residents who need to come to terms with their own emotional and professional perspectives in addition to those of their patients.

Section IV of the book, Reproductive Health Services & Abortion Training: Global Examples, looks at reproductive health services and education from a global perspective. Country studies from Nepal, Ghana, Ethiopia, Columbia, Uruguay and Mexico, and three European examples, Sweden, the United Kingdom and Ireland, describe the systems, models and considerations that inform training and services. The section begins with Chapter 26's global perspective on creating a workforce in sexual and reproductive health, its central role in improving population health outcomes and the need for making it an urgent public health priority. The author summarizes national and global workforce considerations made by the United Nations (UN), World Health Organization (WHO), the Lancet Commission and the US Health Force Commission, the complexities and difficulties in defining and achieving a competent workforce in reproductive health and the progress that has been made in a number of countries, including the USA.

Finally, in Chapters 27 through 35 we present descriptions of systems integration of abortion and reproductive health education. We chose the country examples because many of their efforts are connected to those in the USA through the Fellowship in Family Planning and the Ryan Residency Training Program. Each country's approach is uniquely informed by parameters of legality, the health-care and medical education systems, physician attitudes and leadership and culture.

Family Planning and the COVID 19 Pandemic

During the final editing of this book, COVID 19 spread around the world with devastating effects, particularly on pregnant women. The physicians who care for them, whose training is the subject of the book, could not prepare for the unknown effects of the disease on their patients or on pregnancies. Obstetricians know that respiratory disease, the primary cause of death from COVID 19, takes a particularly grim toll on pregnant women. It is the third most common cause of indirect maternal mortalities. Viral pneumonias are difficult to treat: the case fatality rate (CFR) for pregnant women in the pandemic influenza of 1918 was 27%; for the pandemic flu in 1958 it was twice as high (10%) in pregnancy than for non-pregnant women. The most common obstetrical effects of pneumonia in pregnancy are prematurity, intrauterine fetal growth restriction and demise, and neonatal death. Severe acute respiratory syndrome (SARS), the closest relative of the virus causing COVID 19, took a particularly grim toll on pregnant women. The Zika epidemic showed that new infectious diseases sometimes cause terrible fetal deformities. These past experiences suggest that family planning services are critically important for women during viral epidemics in order to prevent maternal deaths and avoid bad obstetrical outcomes.

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In response to the pandemic, the family planning physicians described in this book cared for a wide range of patients. Some of these physicians became infected themselves and, in turn, infected their families and, subsequently, lost elderly parents. Throughout the course of the pandemic, they struggled to maintain abortion services for all women, particularly those whose lives or pregnancies could be threatened by the infection. They advocated and succeeded in declaring abortion to be an "essential service" in their hospitals and clinics. In some states, for example, Texas, Iowa, Ohio, Louisiana, Oklahoma, Tennessee, Arkansas and Alabama, politicians sought to exploit the pandemic by closing freestanding clinics that were not associated with hospital care, claiming that these abortions consumed medical resources and forcing some women to continue an unwanted pregnancy, risking COVID infection and their own and fetal health. The community of experts supported each other across the country in making contraceptive care available with telemedicine and expediting approval for self- or pharmacy-administered medroxyprogesterone acetate. They exchanged clinical care and protocols in response to the new COVID demands on hospitals and published a *New England Journal of Medicine* Perspective: "Abortion during the Covid-19 Pandemic – Ensuring Access to an Essential Health Service."

This book offers a comprehensive historical review and practical guide for anyone interested in family planning: historians, current family planning providers, educators, researchers or policy makers. By describing the growth and impact of two landmark educational initiatives and the enormous changes they led to along with the experiences in countries on every continent, the reader learns:

- the impact on the education and practice of physicians, particularly ob-gyns, students and nurses
- the policy, institutional and organizational changes necessary to integrate family planning into medical education
- the cultural and political hurdles encountered and practical guidelines and considerations to address them, both in the USA and abroad
- the essential roles of community and systems changes, regardless of the legal parameters, but particularly after legalization, on reproduction
- the impact on women's health by increased access to care through research and advocacy
- the recognition by all medical professionals, societies and governments that family planning care, standards for training and education are an essential part of women's health

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