April 30, 2013

Accreditation Council for Graduate Medical Education
515 North State Street
Suite 2000
Chicago, IL 60654

RE: Proposed Training Standards for Family Medicine
Line Numbers: 1925-1927,Req. Number: IV.A.6.j
Line Numbers: 1029-1071,Req. Number: IV.A.5.a(2).(d).

Dear Family Medicine Residency Review Committee Members:

The National Health Law Program ("NHeLP") is pleased to offer these comments on the proposed training standards for family medicine residency programs in the United States. NHeLP protects and advances the health rights of low-income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state levels. Consistent with this mission, NHeLP works to ensure that all people in the United States have access to preventive health care services.

We write to express our opposition to the Accreditation Council for Graduate Medical Education's ("ACGME") dismantling of the explicit requirements for teaching women's reproductive health. The proposed requirements for certification of competent family medicine graduating residents lack direct inclusion of reproductive health procedures. The former family medicine training requirements stated:

> All residents must be trained to competency in normal gynecological examinations, gynecological cancer screening, preventive health care in women, common STD's and infections, ***reproductive and hormonal physiology including fertility, family planning, contraception, options counseling for unintended pregnancy . . . Residents should become competent in the performance of appropriate procedures*** (emphasis added).

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The new requirements state: “Residents must have at least 100 hours or one month or 125 patient encounters dedicated to the care of women with gynecologic issues, including well woman care.” Procedural requirements would only require competency in performing an endometrial biopsy, Pap smear, and wet mount. In contrast, the Society of Teachers of Family Medicine Group on Hospital Medicine and Procedural Training recommends expanded procedural training to meet educational and workforce needs, including IUD and contraceptive implant insertion and uterine aspiration.

Family medicine providers play a critical role in addressing the essential health needs of underserved individuals and communities, including the need for contraceptive services and supplies. Given the importance of family medicine providers to the health of individuals and communities, family medicine residency training requirements should acknowledge accepted standards of medical care recognized by the various professional medical academies, including the American Academy of Family Physicians. Denying women access to family medicine providers with contraceptive training fails to deliver care that meets medical standards recommending pregnancy prevention. Without the care of these providers, women could experience adverse pregnancy outcomes.

Women already face numerous barriers to contraceptive use, in spite of the near universal agreement in medical practice guidelines that women should receive information about and access to contraceptives to prevent pregnancy. These barriers disproportionately impact low-income women and women of color. Unintended pregnancy rates are highest among low-income women, women aged 18-24, cohabiting women, and women of color.[1] Low-income women have higher rates of unintended pregnancy, as compared to higher-income women.[2] While low-income women are the least likely to have the resources to obtain reliable methods of family planning, they are the most likely to be impacted negatively by unintended pregnancy.[3] It is therefore not surprising that the higher rates of unintended pregnancy among low-income women and women of color result in higher rates of abortions and unplanned births.[4] The ACGME’s rules should not impose additional barriers to contraceptive access that exacerbate these disparities.

Training standards ensure that providers deliver quality medical care. While removing certain training requirements could allow for innovation and reduce the complexity of re-accreditation, ACGME must not disregard the specific health needs of women who depend on the care these providers deliver. Community health centers (“CHCs”) and residency clinics, where family physicians often work, are in the process of doubling in capacity due to Affordable Care Act (“ACA”) increases in funding.[5] These sites have become the new front lines of family planning care. However, this opportunity for increasing access to family planning services is squandered, if family medicine providers lack comprehensive reproductive health training to provide the level of care patients at those centers need.

We therefore oppose ACGME’s decision to remove the contraceptive training requirement for family medicine residents. Family physicians are well-suited to address

unintended pregnancy effectively. Currently, the sponsoring institutions of many training programs have religious affiliations that limit their physicians' scope of practice in family planning, making it difficult to train residents in this essential skill.[6] The existing requirements nevertheless ensure the trainees get reproductive health training, even if it occurs outside of the sponsoring institution. ACGME's proposed decision would further exacerbate the problems created by ideological restrictions; only a specific requirement for contraceptive training results in medical programs finding opportunities to teach this skill.

Comprehensively trained family physicians could significantly reduce the high rates of unintended pregnancy and corresponding health disparities by increasing access to the most effective gynecological methods and procedures (including uterine aspiration), implants and IUDs. This is true now, more than ever, because the ACA requires that women receive contraception without cost-sharing.

We urge you to retain the requirement that family medicine residents learn contraception and options counseling for unintended pregnancy. If you should have questions about these comments, please contact Susan Berke Fogel at (310) 204-6010 or fogel@healthlaw.org.

Thank you for your consideration.

Sincerely,

Emily Spitzer
Executive Director

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[1] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38(2) PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90, 94 (2006), http://www.guttmacher.org/pubs/psrh/full/3809006.pdf.
[2] *Id.* at 93-94.
[3] *See generally* Sheila D. Rustgi, Michelle M. Doty & Sara R. Collins, 52 The Commonwealth Fund Publ'n 1262, *Women at Risk: Why Many Women are Forgoing Needed Health Care* (2009) (addressing impact of cost of health care services on women), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf.
[4] Lawrence B. Finer & Mia R. Zolna, 84(5) *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, CONTRACEPTION 478, 478--85 (2011).
[5] Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010). Amendments to the ACA were included in the Health Care and Education Reconciliation Act of

2010, Pub. L. No. 111-152 (March 30, 2010). *See e.g.,* ACA § 10503(b)(1) (describing anticipated appropriations to CHC operations for FYs 2011 – 2015).

[6]*See generally* National Health Law Program, *Health Care Refusals: Undermining Quality Care for Women* (2010), *available at* http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf (providing an extensive analysis of the adverse medical consequences for women when health care decisions are based on ideological beliefs instead of medical standards of care).