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Workforce Providing Abortion Care and Management of Pregnancy Loss in the US
Nearly 1 in 4 women will have an abortion by age 45 years.1 A critical determinant for access to abortion care is the health workforce. Studies of abortion facilities and clinicians often rely on surveys, which are limited by sample size, or focus on abortion facilities. While these facilities are critical for abortion care in the US, primary care clinicians and others outside of abortion facilities also provide abortions.

The same medications and procedures used for abortion care can be used to manage pregnancy loss. However, abortion and management of pregnancy loss are often treated differently in a policy context, and some clinicians may not provide abortions even if they have the clinical skillset to do so. This cross-sectional study leverages a national medical claims data set to examine the workforce providing abortion care and management of pregnancy loss.

Methods | We used pre adjudicated medical claims from a private data company (IQVIA), obtaining full-year 2019 clinician month-level counts of services (Current Procedural Terminology) and indications (International Statistical Classification of Diseases and Related Health Problems, Tenth Revision [ICD-10]). We identified clinicians providing 2 sets of services: medication (misoprostol and mifepristone) and procedural (dilation and curettage, dilation and evacuation, surgical procedures). Services were categorized as induced abortion or management of pregnancy loss based on ICD-10 coding. We analyzed services and clinicians by clinician type/specialty. This study was approved by the George Washington University institutional review board. Informed consent was waived because the research was not regulated by the US Food and Drug Administration and presented no more than minimal risk to participants.

Results | We found 3550 abortion service clinicians and 22 001 clinicians providing management of pregnancy loss (Table). Of induced abortion clinicians, 3119 (88%) were physicians and 431 (12%) were advanced practice clinicians (APCs). The most common clinicians providing induced abortions were obstetrician-gynecologists (OBGYNs; 2565 [72%]), family medicine (310 [9%]), advanced practice registered nurses (282 [8%]), nurse midwives (89 [3%]), physician assistants (52 [1%]), emergency medicine (49 [1%]), internal medicine (37 [1%]), and pediatrics (20 [0.6%]).

Nearly all clinicians providing management of pregnancy loss were physicians (21 737 [99%]); 264 (1%) were APCs. The most common types of clinicians were OBGYNs (18 943 [86%]), followed by emergency medicine (1243 [6%]), OB/GYN specialty (555 [3%]), and family medicine (515 [2%]). Advanced practice clinicians included 113 advanced practice registered nurses (43%), 43 nurse midwives (16%), and 84 physician assistants (32%). Of the 23 346 total clinicians, 19796 (85%) had medical claims only for management of pregnancy loss, 1345 (6%) had medical claims only for induced abortions, and 2205 (9%) had medical claims for both.

Discussion | This cross-sectional study identifies a small but essential national workforce of clinicians who provide abortions. While most clinicians who provide abortions are OBGYNs, other primary care physicians and advanced practice clinicians are also important providers of these services. Increasing the number of primary care physicians, and others, such as emergency medicine, who provide abortion care can increase access to these services.

We found limited overlap among clinicians who provide abortion and pregnancy loss management. In more favorable policy environments, clinicians who manage pregnancy loss could become abortion clinicians and increase this workforce. In less favorable policy environments, these clinicians may drop out of the workforce because of the fear of retribution associated with providing services that are proximate to abortion care, thus decreasing the abortion workforce.

Abortion coverage is highly restricted under private insurance and Medicaid; therefore, many patients and clinicians cannot or do not bill insurance. Beyond increasingly restrictive payment policies,2 policies that punish clinicians may cause clinicians to stop offering medication and procedural services, reducing access to management of pregnancy loss as well as abortion.

Invited Commentary page 491
Related article page 482
<table>
<thead>
<tr>
<th>Specialty</th>
<th>No. (%)</th>
<th>Medication abortiona</th>
<th>Procedural abortionb</th>
<th>Total (medication and/or procedural)c</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Induced abortion</td>
<td>Pregnancy loss</td>
<td>Induced abortion</td>
</tr>
<tr>
<td>Physicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OBGYN</td>
<td>773 (51.1)</td>
<td>656 (68.8)</td>
<td>2351 (83.4)</td>
<td>18 858 (87.1)</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>4 (0.3)</td>
<td>152 (15.9)</td>
<td>46 (1.6)</td>
<td>1107 (5.1)</td>
</tr>
<tr>
<td>Family medicine</td>
<td>251 (16.6)</td>
<td>49 (5.1)</td>
<td>210 (7.4)</td>
<td>480 (2.2)</td>
</tr>
<tr>
<td>General surgery</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
<td>2 (0.1)</td>
<td>42 (0.2)</td>
</tr>
<tr>
<td>OBGYN specialty</td>
<td>13 (0.9)</td>
<td>10 (1.0)</td>
<td>58 (2.1)</td>
<td>550 (2.5)</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>24 (1.6)</td>
<td>12 (1.3)</td>
<td>20 (0.7)</td>
<td>119 (0.5)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>17 (1.1)</td>
<td>3 (0.3)</td>
<td>15 (0.5)</td>
<td>21 (0.1)</td>
</tr>
<tr>
<td>Other physician</td>
<td>13 (0.9)</td>
<td>7 (0.7)</td>
<td>64 (2.3)</td>
<td>278 (1.3)</td>
</tr>
<tr>
<td>Total</td>
<td>1096 (72.4)</td>
<td>890 (93.4)</td>
<td>2766 (98.1)</td>
<td>21 455 (99.1)</td>
</tr>
<tr>
<td>Advanced practice clinicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APRN</td>
<td>273 (18.0)</td>
<td>37 (3.9)</td>
<td>36 (1.3)</td>
<td>79 (0.4)</td>
</tr>
<tr>
<td>Nurse midwife</td>
<td>89 (5.9)</td>
<td>19 (2.0)</td>
<td>5 (0.2)</td>
<td>24 (0.1)</td>
</tr>
<tr>
<td>Physician assistant</td>
<td>50 (3.3)</td>
<td>7 (0.7)</td>
<td>7 (0.2)</td>
<td>78 (0.4)</td>
</tr>
<tr>
<td>Other health profession</td>
<td>5 (0.3)</td>
<td>0</td>
<td>5 (0.2)</td>
<td>24 (0.1)</td>
</tr>
<tr>
<td>Total</td>
<td>417 (27.6)</td>
<td>63 (6.6)</td>
<td>53 (1.9)</td>
<td>205 (0.9)</td>
</tr>
<tr>
<td>Overall total</td>
<td>1513</td>
<td>953</td>
<td>2819</td>
<td>21 660</td>
</tr>
</tbody>
</table>

Abbreviations: APRN, advanced practice registered nurse; OBGYN, obstetrician-gynecologist.
a Medication abortion includes mifepristone and misoprostol.
b Procedural abortion includes dilation and curettage, dilation and evaluation, and surgical procedures.
c Medication and procedural abortion totals do not sum to total because clinicians may perform more than 1 type of service.

Because of coverage restrictions on abortion services, medical claims data provide an incomplete picture of the abortion clinician workforce. Improving coverage and reimbursement policies, as well as investing in training and removing the restrictive scope of practice policies for APCs, can expand this workforce and increase access to these services.

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Author Contributions: Dr Strasser had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

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Evaluation of Evidence-Based Dual Antiplatelet Therapy for Secondary Prevention in US Patients With Acute Ischemic Stroke

Recommendations for dual antiplatelet therapy (DAPT; aspirin and clopidogrel) for secondary prevention in patients with acute ischemic stroke have evolved over time. Although long-term DAPT was not recommended because of excessive bleeding risk, the CHANCE (Clopidogrel in High-risk Patients With Acute Non-disabling Cerebrovascular Events) trial1 and the POINT (Platelet-Oriented Inhibition in New TIA and Minor Ischemic Stroke) trial2 shifted the focus to short-term DAPT (21-90 days) in patients with minor ischemic stroke (National Institutes of Health Stroke Scale [NIHSS] score ≤3) and found that DAPT was effective in reducing the risk of recurrent ischemic stroke. The American Heart Association and American Stroke Associa-