

“If you can’t be a whole person, it’s hard to be a good doctor.” An Interview with Duke OB/GYN Residency Director Dr. Beverly Gray

Interview conducted by Kaitlin Ugolik Phillips

In the wake of COVID-19 and the overturn of *Roe v Wade*, medical residents—in particular OB/GYNs—are advocating for more family-friendly workplaces and reproductive choice. In this interview, Managing Editor Kaitlin Ugolik Phillips talks with Duke OB/GYN Residency Director Dr. Beverly Gray about the need for policy changes in medical education to improve workforce well-being and cultural competence.

Introduction

As described throughout this issue of the *North Carolina Medical Journal*, recruitment and retention of culturally competent maternal health workers is a key area for policy change if North Carolina is to meet growing health care needs in our state. In this interview, **Dr. Beverly Gray, OB/GYN**, residency director at Duke, discusses the changing medical education landscape in the wake of the stresses of the COVID-19 pandemic and the Supreme Court’s June 2022 decision overturning *Roe v Wade*, leaving legal access to abortion services up to individual state legislatures.

Drawing on her work in gynecology, family planning, community outreach, and education, Gray discusses the evolving concerns of residents and doctors and the changing needs of their patient populations.

“This next generation of physicians is making a change in the culture,” said Gray.

NCMJ: What drew you to focus on community outreach and education within your specialty?

Dr. Beverly Gray: I’ve lived in North Carolina my whole life with the exception of two years abroad as a Peace Corps volunteer focusing on public health education in rural Ecuador. It was during that time that I decided I wanted to pursue medicine, and my journey through medicine led me to OB/GYN because I loved the ability to work with patients in the community where I lived. Patients of reproductive age are often underinsured or low-resource, and so it’s an opportunity to improve outcomes for those patients.

As far as my research focus, a lot of it has been informed by my clinical practice. One of my interests is the patient experience with in-office procedures and how we can reduce pain for patients. I’m also working with a couple of different projects

looking at vaccine hesitancy in the community and how we can provide better education throughout pregnancy for patients, and with a navigation study looking at how we can give patients resources that can help them through pregnancy.

NCMJ: Is there a particular period before, during, or after pregnancy where you see the most significant impact of policy interventions?

Gray: I think preconception care is really important in identifying medical needs, pregnancy desires, and contraception choice. The fourth trimester—or postpartum care—is an important time for the opportunity to make sure that new parents are getting the support that they need. Once someone becomes pregnant, whatever their health state is at that point definitely influences their course of pregnancy. So, if we have opportunities to really optimize patients’ health and get them to be in the healthiest spot possible before they even become pregnant, it’s super important.

There’s a really high unintended pregnancy rate in our state [1]. That’s an area where we can definitely have an impact. If you have an unintended pregnancy and the patient wants to seek abortion care, but either doesn’t have financial means or they find out they’re pregnant too far along in their pregnancy, and they continue that pregnancy, those are higher-risk pregnancies. We know from the Turnaway Study, looking at patients who continue their pregnancy after being unable to receive abortion care, they had much higher rates of poor outcomes [2]. For those patients, that’s an opportunity for us to provide even better care.

I think that extending postpartum Medicaid for a year is such a huge win for the patients of our state. In some communities, access to care is limited, even in the Triangle. With this expansion, there’s not this pressure of having only six or eight weeks to get someone into a primary care appointment, get them diabetes control, do all those sorts of things.

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NCMJ: You have also done some work on physician wellness and parenthood during OB/GYN training. What is that experience like, and how does it impact the well-being of the workforce?

Gray: Historically, medicine has not always been friendly to parents, male or female. Access to leave and time off has been limited. I think over this past decade, there have been a lot of changes within every field, especially in OB/GYN, that have made a difference for people deciding to have a baby during training. We have a lot of residents who choose to have kids in our residency program. We make time for people to have the leave that they need and want so that they can spend time with their families.

I think most residency programs are changing their leave policies to be humane. If you think about the average age that most Americans have kids, it's in their mid-to-late twenties, the same years that people are going through residency, and we're sort of expecting people to put their major life plans on hold. If you look at the data, physicians are much more likely to experience infertility as well [3], which is probably a result of deferring child-bearing until after they complete their training. I don't think we can ask people to make those life sacrifices for the field of medicine. Medicine is critical for the patients we care for, and being a good doctor is important, but I think if you can't be a whole person, it's hard to be a good doctor.

This next generation of physicians is making a change in the culture. If we want to attract people to this field, we have to make it a space where people are vital in their work, but where they also have boundaries between work and home life. It has to come from the top down; you need leaders who are willing to step back and question the status quo to make things better.

NCMJ: We talked about the importance of reproductive health and choice for patients and for providers. How are you seeing the recent Supreme Court decision in *Roe v Wade* affecting the morale of the workforce, and people deciding to go into the field?

Gray: A lot of our residents are just really anxious about what the future will bring. This was not the scenario that they signed up for. I think being limited in the care we can provide depending on what state we live in creates a lot of anxiety for people. There are others who sort of treat it more as a call to action. For us here in North Carolina, we still are an access state, and we hope it stays that way, even though the 20-week ban has just been reinstated. I think there's a lot of energy around maintaining the status quo in North Carolina right now, so that our patients can get the evidence-based health care that they need. People are on a little bit of an emotional roller coaster with it, but are

feeling energized about how we can work to educate the leaders in our state about the importance of this part of comprehensive OB/GYN care.

Even before *Roe* fell, North Carolina had an equity to access issue. Abortion is not covered by state insurance, and roughly half of patients have Medicaid for pregnancy coverage [4]. Most people don't have \$400 or \$500 sitting around for a medical emergency. Ninety-one counties in North Carolina don't have an abortion provider [5], and clinics are mainly in urban areas. If you live in a rural area, you're driving several counties away, and having to get child care—most people seeking abortion care already have kids [2].

What we're really worried about is, if we get to a point where North Carolina has a really restrictive ban, we will more acutely see lives in danger.

Patients who have really severe medical illnesses and folks who are living in a complete ban state are living that reality right now, and it's really scary.

NCMJ: Is there also a concern about retention of physicians?

Gray: We're a top residency [at Duke] and we attract some of the most talented physicians every year to come to our practice, and a lot of those folks end up staying in North Carolina. Applicants this year are becoming savvier around the local politics of the place they're moving to—what's the forecast of what's going to happen? These are also young people who want access to reproductive health care. So, I think it has the potential to impact all the specialties, not just OB/GYN. The other thing that not a lot of people are talking about is the potential economic impact. Right now, we have a ton of folks moving to North Carolina for a variety of business opportunities, but I think that could change if we have a restrictive ban.

One thing we've been working on in our department is an advocacy group we started about a year ago. The Duke Reproductive Health Equity and Advocacy Mobilization team has been doing advocacy training, op-ed training, meeting with our local representatives. It's been really informative about how we as medical professionals can convey our experience to those who are making laws and share what we're seeing on the front lines, and how those laws influence patient outcomes and patient care. There are so many areas within OB/GYN where advocacy is needed. We're in a maternal health crisis right now, abortion rights are at stake, there are access to care issues, we need family leave. Even if you're not involved in advocacy, there are ways and avenues to get involved and to learn more about the politics of the state and how they influence patient outcomes. NCMJ

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