Women's Health Issues 27-5 (2017) 614–619

WOMEN'S HEALTH ISSUES
www.whijournal.com

Health Care Providers

Exploring How Residents Who Partially Participate in Family Planning Training Determine Their Level of Participation

Jema K. Turk, MPA, MA, PhD [a,b,c,*], Felisa Preskill, MPP [a,b,c], Alecia Fields, DO [a,b,c], Uta Landy, PhD [a,b,c], Jody E. Steinauer, MD, MAS [a,b,c]

[a] *The Bixby Center for Reproductive Health Research and Policy, San Francisco, California*
[b] *Department of Obstetrics, Gynecology and Reproductive Sciences, San Francisco General Hospital, San Francisco, California*
[c] *Department of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco, San Francisco, California*

Article history: Received 15 September 2016; Received in revised form 22 March 2017; Accepted 24 March 2017

A B S T R A C T

Objectives: The Accreditation Council for Graduate Medical Education (ACGME) requires that obstetrics and gynecology residency programs provide access to abortion training, though residents may elect to opt out of participating due to religious or moral objections. While clinical benefits of partial participation have previously been explored, our study aimed to explore how residents navigate partial participation in abortion training and determine their limits.
Study Design: This study was qualitative in nature. Between June 2010 and June 2011, we conducted 26 semi-structured phone interviews with residents who opted out of some or all of the family planning rotation at 19 programs affiliated with The Ryan Residency Training Program. Faculty directors identified eligible residents, or residents self-reported in routine program evaluation. We analyzed data using the conventional content analysis method.
Results: We interviewed all 26 (46%) of 56 eligible residents willing to be interviewed. Three main categories constituted the general concepts concerning resident decision-making in training participation: (1) variation in timing of when residents determined the extent of participation, (2) a diversity of influences on the residents' level of participation, and (3) the perception of support or pressure related to their participation decision.
Conclusions: The findings indicated that residents who partially participate in abortion training at programs with specialized opt-out family planning training weigh many factors when deciding under what circumstances, if any, they will provide abortions and participate in training.
Published by Elsevier Inc. on behalf of Jacobs Institute of Women's Health.

The Accreditation Council for Graduate Medical Education requires that obstetrics and gynecology (ob-gyn) residency programs provide access to abortion training and allows individual residents to opt out of training owing to religious or moral objections. Since 1992, the proportion of residency programs with routine training increased from 12% to 50%, and in the most recent study an additional 40% report elective, 'opt-in' training and 10% report no training (Almeling, Tews, & Dudley, 2000; Eastwood, Kacmar, Steinauer, Weitzen, & Boardman, 2006; Jackson & Foster, 2012; MacKay & MacKay, 1995). Routine training status indicates that training is integrated into the program as an expected rotation, and that to be excused residents must formally opt out. The Ryan Residency Training Program (Ryan Program) was established in 1999 to assist ob-gyn residency programs in the United States and Canada establish training in family planning and abortion. There are currently 91 ob-gyn residency programs affiliated with the Ryan Program (Ryan Residency Training Program, 2016).

Studies of residents who fully participated in abortion training demonstrated that exposure leads to improved clinical skills and more accepting attitudes about abortion (Freedman, Landy, & Steinauer, 2010; Jackson & Foster, 2012; Macisaac & Vickery, 2012; Steinauer, Silveira, Lewis, Preskill, & Landy, 2007; Steinauer, Turk, Fulton, Simonson, & Landy, 2013). Studies of residents who opted out of components of abortion training found significant benefits of partial participation. Not only do these residents experience improved clinical skills, such as contraceptive care, ultrasound examination, and miscarriage

The authors assert that we have no financial or other conflicts of interest.
This study is funded by the Susan Thompson Buffett Foundation.

* Correspondence to: Dr. Jema K. Turk, MPA, MA, PhD, San Francisco General Hospital, 1001 Potrero Ave. 6D-14, San Francisco 94110, CA. Phone: (415) 206–4046; fax: (415) 206-4527.
E-mail address: Jema.Turk@ucsf.edu (J.K. Turk).

1049-3867/$ - see front matter Published by Elsevier Inc. on behalf of Jacobs Institute of Women's Health.
http://dx.doi.org/10.1016/j.whi.2017.03.013

management, but they also cite improved ability to provide patient-centered care and changes in attitudes about abortion as beneficial aspects of their family planning rotation (Steinauer, Hawkins, et al., 2013; Steinauer, Turk, et al., 2014).

Although we know that partially participating residents consider the family planning rotation worthwhile, little is known about how these residents determine the extent to which they are willing to care for women who consider or want to terminate their pregnancy. A recent qualitative study found that the decision to opt in or out of abortion training is complex, because some residents struggle with their professional obligation when they feel it conflicts with their personal, moral, or religious beliefs (Singer, Fiascone, Huber, Hunter, & Sperling, 2015). We wanted to better understand how residents determine their level of participation and what role resident training programs play in the decision making process. Our hope is that an increased understanding of partially participating residents' experiences and the process by which training is facilitated will further enhance training and help to ensure that all residents are trained to provide more competent and empathic care.

Materials and Methods

At the time of data collection, there were 64 established Ryan Programs. Residents at Ryan Programs were deemed eligible for participation in our study by either one of two methods: 1) if identified by the faculty member responsible for family planning training as a resident who "opted out of some part of family planning training," or 2) the resident indicated so themselves on the Ryan Program's post-rotation evaluation survey. The Ryan Program routinely administers a post-rotation evaluation survey at the end of the rotation, which inquires about rotation content, resident experience, feedback, and consent for future research. Since 2008, the survey has included a question about participation: "Did you opt out of any portion of the family planning training?" Between 2008 and 2010, approximately 460 residents completed post-rotation surveys, and of those, 322 consented to future studies. Of those, 48 indicated they had opted out of some part of the family planning training. Thus, 48 residents identified themselves as a learner who opted out of some part of the training, and an additional 8 residents were identified by their Ryan Program directors, yielding 56 residents eligible to participate in our study. We invited all 56 residents by e-mail to complete a web-based, quantitative survey at the end of which they indicated willingness to be interviewed.

We conducted in-depth, semistructured interviews with current and former residents who opted out of some or all of the family planning-related rotation by phone. We asked participants about what skills they gained on the rotation, interactions with faculty and peers about opting out, changes in attitudes about abortion, and benefits of the rotation. Interviews continued until every eligible resident who agreed to participate was interviewed. These interview data also served as the source for an analysis previously published in 2014 (Steinauer, Turk, et al., 2014).

Two social science researchers conducted the interviews (researcher A interviewed 14 residents, researcher B interviewed 12). Both researchers trained in qualitative methods in their respective graduate programs, and were further advised specifically on this study by a leading qualitative researcher at their institution. Neither researcher A nor researcher B had ever been in contact with these residents before this study, nor were in any position of authority to the residents.

Data analysis was conducted with conventional content analysis. Researchers allowed codes and categories to emerge from the research results instead of using previously defined theories and categories (Hsieh & Shannon, 2005). All interview recordings were transcribed verbatim. The two researchers carefully reviewed the transcriptions after an initial review and extraction of the general categories and themes. After open coding 16 transcripts, researchers decided on preliminary codes. We then coded the remaining transcripts (and recoded the original ones) using these codes and added new codes when we encountered data that did not fit into an existing code (Mayring, 2000). Wherever disagreements in codes presented, a third researcher determined the final code(s).

All ethical considerations, such as introducing the researcher to participants, explaining the study goals, keeping participants' information confidential, and allowing the participants to leave the study at any time and to determine the time and date of interviews, were respected. All participants provided their informed consent orally for participating in the study and for recording their interviews. We gave participants a $50 Amazon gift card as compensation for their time. A copy of the interview protocol can be obtained by writing to the primary author.

This study was approved by the University of California San Francisco's Institutional Review Board.

Results

Over a 1 -year period from June 2010 to June 2011, we interviewed 26 of the 56 eligible residents (46%) by phone. Each interview lasted between 18 and 40 minutes, depending on how participants answered the questions. Of the 30 physicians who were invited but did not participate (56% of eligible residents), 24 were women; 5 trained in North/Northeast, 10 in the Midwest, 9 in the South/Southeast, and 6 in the West; 4 had completed training and 26 were current residents. Ten of these residents were unable to schedule an hour of time for an interview, and the other 20 did not participate in the interviews because they did not respond to our interview requests.

Of the 26 participating residents, a Ryan Program director identified 6, and 20 residents indicated their interest in participating in future studies in the post-rotation evaluation survey. The residents came from 19 different training programs, demonstrated a range of motivations for opting out of training, and described varying levels of participation, from doing abortions only for certain indications to only observing aspects of care. The largest subgroup ($n = 16$) did not provide abortions but participated in other aspects of care, including contraceptive care, counseling, and ultrasound examinations. Table 1 summarizes participant characteristics.

Our analysis of the data regarding how residents navigate participation in family planning training yielded three main content categories: (1) variation in the timing of participation decisions, (2) diversity of influences on their participation level, and (3) resident perception of facilitator and/or program support and pressure of their participation decisions.

Category 1: Variation in the Timing of Participation Decisions

Residents varied regarding when in their medical training they determined their level of participation. More than one-half of study participants said they knew before residency that they would opt out of some or all of the integrated abortion training.