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Obstetrician-gynecologist experiences with abortion training: physician insights from a qualitative study☆

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Abstract

Background: Abortion is one of the most contested, yet common surgical procedures in the United States and a required component of obstetrics and gynecology resident education. Approaches to abortion training are variable.
Study Design: We conducted in-depth interviews with 30 physicians who had graduated 5–10 years prior from four US residency programs with routine abortion training. Interviews focused on their experiences with abortion during training and in practice.
Results: Graduates' positive and negative experiences demonstrated that many valued teaching about the social issues surrounding abortion as well as training in surgical skills. Respondents found training rewarding when attending physicians openly discussed their personal commitment to abortion practice, respected differences of opinions about abortion and demonstrated high regard for abortion training. Some residents who opted out of surgical training for abortion valued partially participating in the rotation.
Conclusions: Many physicians-in-training consider didactics related to the social context of care and respect for moral boundaries important components of abortion training.

Keywords: Abortion; Professionalism; Residency training; Qualitative; Values clarification; Opt-out

1. Introduction

The overall number of abortion providers in the United States declined by 14% from 1992 to 1996, 11% from 1996 to 2000 and 2% from 2000 to 2005 [1]. In 2005, 69% of metropolitan counties and 97% of nonmetropolitan counties in the US had no abortion provider [1]. In parts of the country lacking skilled abortion providers, women may have to travel several hours for the procedure. The American College of Obstetrics and Gynecology (ACOG) supports "education about family planning and abortion as an integrated component of obstetrics and gynecology residency training" for a number of reasons, including the need to redress the shrinking abortion provider base in order to improve patient access to safe abortion services [2].

Few medical schools include abortion in the preclinical curriculum and a minority of ob-gyn clerkships include routine exposure to abortion care [3,4]. In 1996, the Accreditation Council for Graduate Medical Education (ACGME) mandated that exposure to abortion be included in ob-gyn residency programs. By 2004, routine inclusion rose to 51% of ob-gyn residencies [5–8]. The remaining half offer it only as an off-site elective and there is considerable variability in the teaching style and quality in both routine and elective abortion training [9]. A critical concern of some residency directors is training in the social realm of abortion [10,11]. Some include teachings on the public health history of abortion and the range of reasons why their patients get abortions in addition to the necessary medical and surgical skills. While not every area of residency training will include teaching toward the social and political context of care, these teaching physicians typically employ such instruction in order to (1) motivate residents to make pregnancy termination part of their future practice, (2) encourage empathy and professionalism in counseling patients and/or, (3) at

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minimum, encourage physicians to be knowledgeable about nearby treatment options.

This research is exploratory in nature and not hypothesis driven. It was undertaken in order to understand physicians' experiences with abortion training and abortion practice because quantitative research shows that nationally only half of ob-gyn residents who intend to include abortion in their practice ultimately do so [12]. In addition, such research says little about the reason for this outcome. Given the contentious politics of abortion, the declining provider base (despite increases in those being trained) and the inconsistencies in training approaches, the authors wanted to study in-depth how physicians remembered abortion training and what shaped their decisions about abortion practice after residency. The qualitative data and analysis we present here draw primarily from physician narratives about their abortion training experience.

2. Methods

Ob-gyn residency programs that offered routine, opt-out abortion training since 1996 were chosen for study. We purposively selected programs that conduct abortion training in the hospital of the residency program because we wanted to interview physicians who had been trained in the most normalized medical setting for abortion. We expected that the insulation of the hospital setting would minimize social confrontation over abortion (i.e. abortion clinic protestors) such that we could identify variables affecting abortion training and postgraduate provision that were more directly modifiable.

We purposively selected four sites representing four regions in the US (West, Midwest, Northeast and South). We mailed a letter of introduction to the residency program directors of each of the four programs and asked their permission to forward our letter of invitation to all graduates (approx. total 150) from the years 1996–2001. The lead author (LF), a sociologist with training in qualitative methodology, completed in-depth interviews with respondents in person and over the phone. Interviews ranged between 30 and 60 min and focused on participants' narratives about abortion training and their professional experiences thereafter. Topics covered in detail during the interview included physicians' memories of abortion training, professional trajectories since residency, decision making around abortion practice, and emotional experience of providing abortions. Questions were open ended and allowed the participant to expand upon themes in an unstructured or nonlinear fashion as relevant to the narrative. The interviewer kept track of questions answered so that interviews completely covered the necessary subject matter without interrupting the narrative flow. Several questions related to memories of abortion training. Some examples are as follows: (1) Please describe a typical day of abortion training. (2) How was the experience of performing second-trimester abortions different for you than first-trimester abortions? And, (3) What happened when residents opted out of abortion training? When participants needed prompting, the interviewer followed up with more specific questions to elicit more detailed answers.

Interviews were transcribed, and analytic themes that emerged were coded using Atlas.ti 5.0 (Atlas.ti Scientific Software Development GmbH, Berlin, Germany) using grounded theory analytic methods, which take an inductive approach in order to generate theory from the data, rather than test theory. Research questions are initially very broad. After examining the data and noting meaningful themes recurring in multiple interviews, the researcher formulates theories and/or connects existing social theories to the data that offer explanatory value. One of the authors (LF) analyzed and coded the research as part of her sociology doctoral dissertation at University of California, Davis. Problematic or confusing findings were discussed with the co-authors, and both the social science and medical literature were used to help clarify or corroborate aspects of the narratives. The study was approved by the University of California, San Francisco Institutional Review Board. The initials used to denote physicians' names are based upon pseudonyms. The residencies will be referred to as Res1, Res2, Res3 and Res4 to ensure the actual residencies are not identifiable. Thus, no persons, institutions, cities or regions will be identified in the article in connection with the interview data.

3. Results

Forty physicians returned signed consent forms, a response rate of approximately 27%. Thirty physicians completed interviews with at least five interviews from each region's residency program: South (5), West (9), Midwest (9) and Northeast (7), although some had moved to different regions to practice (see Table 1). Ten physicians were unavailable or unreachable for interview. Respondents' ages ranged between 34 and 50 years, with most clustering around 40 years. Five physicians initially opted out of performing abortions during training, and four of those participated partially in some aspect of the rotation. Table 1 shows the group's distribution by gender, region and practice settings.

Residents' experiences with abortion training at all four sites were widely positive. Training experiences were characterized as negative by three out of the 30 study participants. Based upon a comparison of multiple graduates' accounts, Residency 1 (Res1) and Residency 2 (Res2)

Table 1
Region of practice at time of interview

	Northeast	Midwest	South	West	Total
Male	2	1	2	3	8
Female	4	6	4	8	22
Total	6	7	6	11	30