

Original research article

Attitudes of obstetrics and gynecology residents toward abortion participation: a Philadelphia area survey

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Abstract

Objective: The objective of this study was to evaluate the willingness of Philadelphia obstetrics and gynecology residents to participate in three abortion procedures for various fetal conditions.

Methods: Anonymous questionnaires were distributed to 310 residents from 18 programs. The survey asked the residents whether they would participate in first trimester dilatation and evacuation (D&E), second trimester prostaglandin induction or second trimester D&E for the following conditions: lethal fetal anomaly, nonlethal anomaly with certain long-term functional consequences, possible long-term functional consequences, little or no long-term functional consequences and elective abortion of a normal fetus.

Results: Of the 148 respondents, the percentage of residents who would participate in a second trimester D&E for each fetal condition was significantly lower than that for a first trimester D&E ($p \leq .001$). Additionally, for each abortion procedure, the participation rates consistently fell for lesser degrees of fetal severity. Participation was significantly associated with preferences regarding abortion legislation and personal abortion stance.

Conclusion: Resident attitudes regarding abortion participation were related to severity of the fetal condition, gestational age and procedure type.

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1. Introduction

With the widespread utilization of both serum aneuploidy screening and obstetrical ultrasonography, chromosomal and structural fetal abnormalities are often detected prior to viability, allowing parents options regarding termination of pregnancy. However, the number of abortion providers in the United States has been steadily decreasing since 1982. In 2000, the number of abortion providers, which included clinics, hospitals and physician offices, was 1819, an 11% reduction from 1996 and a 37% reduction since the highest level was recorded in 1982. As of 2000, 87% of counties in the United States had no

abortion providers, a number that has been steadily increasing since 1978 [1].

The proportion of terminations performed in the United States for a fetus with a genetic or structural fetal abnormality is not known. However, in 2000, 5.7% of all abortions in the United States were performed at 16 weeks or beyond [2], which would likely include all terminations due to abnormalities detected with second trimester screening. As of 2001, 33% of abortion providers offered pregnancy termination after 20 weeks of gestation, an increase from 22% in 1993 [3].

Previous studies have shown a clear link between residency training in abortion techniques and later provision of abortion services [4,5]. We therefore sought to determine the regional attitudes of obstetrics and gynecology residents in the Philadelphia area toward participation in three abortion procedures for various fetal conditions and to explore variables that might influence their involvement.

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2. Materials and methods

An anonymous four-page abortion survey that consisted of three sections was created. The first 2 pages asked each resident whether he or she would personally provide or assist in a first trimester (<14 weeks) dilatation and evacuation (D&E), a second trimester (14–23 weeks) prostaglandin induction of labor or a second trimester D&E for each of five fetal conditions of varying severity. These conditions included a lethal genetic or structural fetal anomaly (e.g., anencephaly, Trisomy 18, Trisomy 13); a serious, usually nonlethal genetic or structural abnormality with certain long-term functional consequences (e.g., meningomyelocele, Down syndrome); a correctable nonlethal abnormality with possible long-term functional consequences (e.g., tetralogy of Fallot, hydrocephalus); a correctable abnormality with little or no long-term functional consequences (e.g., gastroschisis, cleft lip); and an elective abortion with a normal fetus. A sixth scenario allowed residents to indicate that they would never participate in an abortion procedure under any condition. Willingness to participate was to be indicated by a check mark for all 18 abortion type–clinical scenario pairs.

The third page of the survey asked for demographic information and abortion attitudes including age, sex, ethnicity, residency year, parenthood, abortion stance (pro-life, pro-choice or neither) and position on abortion legislation (less restrictive, more restrictive or no change needed). Residents were also asked if their program provided each of the three abortion procedures either electively or for genetic/structural anomalies or whether no abortion services were offered.

The final page asked for the name of each resident's program and resident year in order to track institutional response rates for each program. As this additional information could link responses to individual residents, the sheet was to be detached and returned separately from the remainder of the survey.

It was calculated that there were a total of 310 obstetrics and gynecology residents from 18 programs with membership in the Philadelphia Obstetrical Society. Surveys were initially directly distributed to the residents in May 2003 during Resident Education Day, a widely attended conference held annually by the Philadelphia Obstetrical Society. Surveys were collected from the residents on the same day as the educational program. Immediately following the conference, each of the 16 program directors and 2 secretarial coordinators (1 director was on military leave and 1 was on maternity leave) was personally contacted and asked to distribute the surveys to residents who had not previously completed the questionnaire. Each program director or coordinator agreed to cooperate with the study. Surveys were then either mailed or e-mailed to all programs as per request. Multiple follow-up phone calls were made to program directors if surveys were not returned. No survey sheets were collected after June 30, 2003.

The study protocol was submitted to our institutional review committee, which granted an exemption from formal review as our survey was anonymous and did not collect any personal health information.

Statistical tests included Student's *t* test for parametric data, χ^2 or Fisher's Exact Test for proportions and the McNemar test, all performed on SPSS version 10 (SPSS, Chicago, IL, USA). Due to the large number of statistical comparisons, statistical significance was set at a *p* value of .001.

3. Results

A total of 148 surveys was returned, for a response rate of 47.8%. Individual program response rates varied from 0% to 100%. The list of residency programs and institutional response rates is shown in Table 1.

Resident responses to individual questions were not included in our analysis if question marks were used, as occurred with three respondents. Additionally, two residents gave contradictory information, either by indicating that

Table 1
Residency programs and response rates

Institution	Rate	Institution	Rate
Abington Memorial Hospital	13/16 (81%)	Pennsylvania Hospital	4/24 (17%)
Albert Einstein Medical Center	4/16 (25%)	Philadelphia College of Osteopathic Medicine	9/11 (82%)
Christiana Care Health Services	8/16 (50%)	Reading Hospital and Medical Center	4/12 (33%)
Crozier–Chester Medical Center	9/12 (75%)	St. Luke's Hospital	5/12 (42%)
Drexel University College of Medicine/Hahnemann Hospital	4/24 (17%)	Temple University Hospital	10/20 (50%)
Hospital of the University of Pennsylvania	0/24 (0%)	Thomas Jefferson University Hospital	11/32 (34%)
Lankenau Hospital	10/12 (83%)	York Hospital	3/12 (25%)
Lehigh Valley Hospital	1/16 (6%)	University of Medicine and Dentistry of New Jersey/Cooper University Hospital	15/15 (100%)
Penn State Geisinger Health System–Milton S. Hershey Medical Center	10/16 (63%)	University of Medicine and Dentistry of New Jersey–School of Osteopathic Medicine/Kennedy Health System	13/20 (65%)

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