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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

appeared to devote more faculty time to abortion curriculum and teaching than Residency 3 (Res3) and Residency 4 (Res4). Physicians reported that Res3 and Res4 had high patient volumes and relatively little faculty teaching during most of the period this physician sample was trained. Substantial changes were subsequently made in both programs according to the experiences described by respondents who had graduated in the most recent years of the sample. In contrast, Res1 and Res2 prioritized faculty teaching time for abortion throughout the period this sample was trained, and their abortion services were reportedly well staffed. Below we present physicians' assessments of what worked well in abortion training and what did not. Assessments that recurred with regularity in the transcripts were grouped into three analytic themes. Overall, physicians remembered training most positively when attending physicians (1) openly discussed why they did abortions, (2) respected moral boundaries of residents who opted out of training and (3) considered abortion training to be valuable for surgical and clinical skill development.

3.1. Candid discussion of abortion

Several residency graduates mentioned in their interviews that they felt it was helpful when faculty physicians took time to explain their reasoning for providing abortions despite the contention and stigma surrounding the work. Faculty members who have been doing abortions for decades often told their students about the morbidity and mortality they witnessed before legalization when women tried to self-abort or went to unsafe illegal providers, later turning up in emergency rooms very sick or dying. Dr. B, a Res2 graduate, explained, "[The clinic director] would tell us the whole history of the clinic and basically give a pep rally to everyone about how important abortion rights are because it was so difficult for people to [legalize abortion]." Another Res2 graduate, Dr. N, similarly characterized a different senior faculty member who taught in the abortion clinic. She said, "The director of the residency program…he's like one of the old guards and I remember him talking about what it was like before [abortions] were available." Faculty helped residents to feel positively about learning to perform abortions when they shared their own motivation for performing abortions, whether grounded in the ethics of public health, social justice or personal freedom.

Ideological concordance was not required to appreciate candid discussion of the residency program's commitment to abortion work. Dr. H, a graduate of Res2, chose not to perform abortions based upon his religious objections. Yet, he felt a professional obligation to develop comfort and proficiency with nonsurgical aspects of abortion care.

> I, for one, really appreciated the up-front part of the training, and it was not something that you were caught off-guard with. In your interviews they had mentioned that it was a part of their curriculum and program…I think that since as a nation we have chosen that we are going to provide the service, I think it needs to be part of training programs. And needs to be kind of up-front like that. Because I think you need those who do the procedures and those who counsel for the procedures. And I feel like I fall in that counseling category.

Res1 set aside time in the abortion rotation for lectures on both the psychosocial and medical aspects of abortion care. A graduate of Res1, Dr. G, said,

> We did have a formal abortion curriculum…As an intern, when you were doing the abortions you would do a lecture [that morning] and then spend the day in the clinic…I think that was what spawned discussions for a lot of people… if I had something that I was uncomfortable or unsure about, I felt like I could just approach [my attendings] with questions or discussions.

These physicians valued hearing what motivated faculty physicians to provide abortion as well as learning in an environment that acknowledged the social and political context of care. Instead of responding to the politics of abortion by avoiding direct discussion of the issue, engaging with the "why" of abortion work [11] allowed these residents the opportunity to make the training experience meaningful.

The absence of direct discussions of the social and moral issues surrounding abortion could in fact be an alienating experience. Dr. S. from Res3 was particularly bothered by the fact that his program seemed to avoid discussion of abortion. He recalled,

> It was handled as if it would be a usual procedure, like delivering a baby, doing a C-section, doing a hysterectomy, tying somebody's tubes and so on. And I think it's, it's not the usual procedure. There's lots of emotional and moral issues that are involved in it.

When asked what he would change about his experience with abortion training Dr. S said,

> The position of the faculty of the institution should be clear towards abortion …It should be more explicit. Don't put it under the carpet. Just discuss it frankly… I never read a document about it …And I think given the charge in the air here and the climate in the United States, I think you cannot, you cannot avoid that.

For Dr. S, the social and political context of abortion warranted discussion by the residency program, beyond what would be expected for less contested medical training rotations and services. While Dr. S considered abortion to be a personal decision and not one that should be illegal, his negative experience may have shaped his postresidency practice. He ceased providing abortions upon graduating and does not refer his patients requesting abortion to known providers. In his current practice, he explains, "I just tell them to look at the yellow book. And, you know, if you open the yellow book, on the first or second page immediately there's this huge ad about abortion."

3.2. Respect for moral diversity and boundaries

Some programs encouraged residents who opted out of performing abortions to participate in the abortion training rotation by observing or helping the service with preoperative or postoperative care. For example, a Res2 graduate, Dr. H, who opted out recalled what he did during his partial participation,

> [We learned] how to clinically size the uterus, check for villi and stuff afterwards, and a lot of those skills are things that I use in my day to day practice… [I] helped with the counseling. I helped, hopefully, alleviate people's fears and counsel them about the procedure and then, helped them get on a[n] alternative form of contraception afterward. If you chose not to do the procedure you helped up to the point of doing it and then checking the tissue and stuff [and] talking to the patient afterwards.

Partial participation was remembered as a positive experience when residents' abortion beliefs and boundaries were respected. Of the five physicians in the study who opted out initially, four participated partially in abortion care. In regard to his attending physicians, Dr. H said, "We had different views, but the thing I liked was there was no real condemnation on anybody's part pro or against." Dr. H did not change his views on abortion. However, the exposure to abortion care and residency didactics did help him develop empathy for abortion providers and patients. He continued, "There is some respect for humanity going on inside those walls. It's not as diabolical as it seems from an outside observer."

Dr. H credits his positive experience with motivating him to develop relationships with known abortion providers in his postresidency practice, which he has accessed when his patients have requested abortion referrals. While he firmly opposes abortion, he ultimately concluded that the moral discomfort of partial participation in abortion training is worthwhile.

> I think that it's good for it to be hard and for you to, early in your career, decide how you are going to face the issue and deal with it. Because I think it is an integral part of the role of an ob-gyn…the reality of at least providing the counseling for patients day in and day out.

Dr. C, an opt-out physician from Res1, also appreciated that her exposure to abortion care helped her develop empathy for abortion patients. "Coming face-to-face with the problematic…the situations that lead [women] to have an abortion really opened my mind to their needs… and really helped me be very nonjudgmental about the whole thing." Dr. C was also aware how her colleagues reacted to being inconvenienced by her opting out.

> This was my choice to not do harm but…there was definitely some awkwardness at times with, whether attendings or other residents, in terms of my position and their position, of potentially creating more work for them. But it wasn't, as I think back at it, it wasn't anything extreme and it wasn't malignant.

One opt-out physician, Dr. R, from Res3, had a very negative experience with partial participation. She had not initially intended to participate in abortion training at all, but her residency's abortion clinic was understaffed, and she felt obligated to help out.

> I could see it was a problem getting enough residents to help staff the pre-op patients. So I said, "You know what? Fine. These women have made their decision. I'm not counseling them about it. I'm just going to make sure that they're safe to undergo the procedure. I'll pre-op them, but I won't consent them. So the resident that's doing the procedure can consent them that day or whatever." But I said that I'll be happy to go through their medical history, their allergies, all that stuff.

However, she found herself in a difficult situation one day in the abortion clinic when the primary resident did not show up. With patients prepped and waiting, she was under pressure from staff and other residents to "at least" consent the patients. The situation led to upsetting confrontations for Dr. R., "I was trying to help out and it was actually a worse situation than if I had just been adamant like some of the other people in my class that wanted absolutely nothing to do with it."

Dr. R's abortion service was poorly staffed by both resident and attending physicians. The boundaries she set around what work she was willing to perform were not respected. Unlike the other residents who opted out in her program, she demonstrated some openness to participating in limited aspects of abortion care. She ultimately concluded that it is morally safer not to get involved at all.

3.3. Valuing the training

In addition to the public health and social justifications for providing abortion in practice, residency faculty sometimes emphasized how competency in abortion care could translate to stronger surgical skills, better complication management and more sophisticated emergency care. Individuals expressed appreciation for the skills they acquired, reflected in similar statements to those they heard during residency about the value of the abortion training. Most study participants ultimately came to view the training as important. A Res2 graduate, Dr. Z said, "It just makes me better in surgery when I do…hysteroscopy or D&Cs for bleeding problems or any kind of procedures to get into the uterus. It's the exact same skills that you need."

Physicians gave examples of how the training led to excellence in complication management during miscarriage and surgical facility with other intrauterine procedures. In particular, Dr. T felt abortion training improved her confidence in managing hemorrhage.

> I'm not as scared of the uterus… whether it's a postpartum hemorrhage or whether it's bleeding during a D&E, D&C, whatever…you have ways you can decrease it. [Physicians without abortion training] haven't seen the true-I mean, how many postpartum hemorrhages does one have in a year? Not

that many.—But they haven't just seen the potential for the uterus to relax and bleed.

Dr. D, whose private practice group does not allow physicians to offer abortions, finds that what he learned from abortion training nonetheless translates well to the rest of his work, "I think I have skills that are much more refined, both procedurally and with the care of my patients socially and emotionally. It makes me a better physician."

In contrast, residency graduates from Res4 referred to the abortion rotation as "resident-run," "unsupervised" and "scut work" — the polar opposite of valued medical work. Dr. V said, "They used the interns to run the clinic, and that's what we were there for. And there was nobody there to educate us." While Dr. V was the only Res4 graduate to regard abortion training as wholly negative, few interviewees from Res4 left residency wanting to perform elective abortions thereafter. One said, "I just felt like I'd done enough."

4. Discussion

At Res1 and Res2, where attending physicians consistently prioritized teaching time and demonstrated high regard for abortion training, graduates shared more positive stories about the training experience and how it has informed their abortion counseling and referral practices, although, as shown elsewhere [13], professional barriers ultimately prevented most from performing abortions. In contrast, positive mentorship stories were largely missing from the interviews with graduates from Res3 and Res4, and their level of interest in ensuring quality abortion counseling and referral practices was more variable.

Prioritization of faculty teaching time during abortion training may not only help to improve understanding of the public health and social context of the work, and prevent disrespectful interactions between residents under pressure, but can also affirm that the residency program considers it valuable and legitimate medical training. In our interviews we found that avoiding the social issues of abortion during abortion training is not neutral and benign as often assumed. For some, less comprehensive curricula and didactics can be detrimental to the development of professionalism in relation to abortion and referral practice.

Other studies of medical work have also found that residents are generally more likely to conceptualize a task as having value if they perceive the task as having training merit and if they have been asked by someone with higher authority (an attending physician) to do the work (as opposed to staff) [14]. The shortage of faculty allocated to some abortion training clinics can make the work appear devalued and even marginalized. The unwillingness of a program to allocate time and resources can have the effect of delegitimizing abortion training and leave residents in a position where abortion provision is part of their job, yet it appears to be regarded as morally suspect work. Such a learning environment may not foster professionalism and respect for abortion care (and the patients seeking that care) among residents.

Partial participation in the abortion rotation was transformative for the few residents who were trained in supportive, well-staffed abortion clinics. Encouraging residents who opt out to partially participate in abortion training, while fostering an environment of respect for differing beliefs around abortion, can create empathy on all sides. No program can or should legally force residents to participate in abortion care, but those who initially opt out may desire the option of partial participation, if they can be assured of a learning environment that respects their moral boundaries. The goal of such bridge building is to create a more professional and compassionate culture of care among ob-gyns whereby physicians who do not want to perform procedures can, at a minimum, make nonjudgmental and informed referrals (direct or indirect) to patients seeking abortion.

Residents who participate in abortion training partially and fully should be introduced to a values clarification curriculum in use in some residencies and medical schools. Such a curriculum involves setting aside time for residents to discuss their feelings and judgments about abortion so that they can better understand themselves and their own behavior toward patients. Such examination and awareness can improve professionalism in physician–patient interactions where unrecognized judgments might impact the provision of care. Values clarification curricula are also a way to foster tolerance in the medical community by building in productive ways for residents to communicate about abortion and other sensitive topics.

Given that abortion remains one of the most common surgical procedures for women in the United States, the hope is that even physicians who do not want to provide abortion (for any reason) will be able to support their patients through the referral process in a patient-centered manner. Because ob-gyns are often the primary provider of care for women, it is their professional responsibility to be surgically competent to perform the procedure and/or to be ready to make a safe referral, as ACOG now requires [15] and medical ethicists advocate [16]. Thus, physicians should be encouraged to treat patients who choose abortion respectfully. They will be better equipped to do this if they themselves are shown respect and tolerance during abortion training.

This article derives from the in-depth study of a small sample of physicians from diverse backgrounds and does not purport to make broad conclusions that are representative of a larger population. Two elements of self-selection may have caused a predominance of positive recollections about abortion training: (1) that these physicians had selected a residency program with a long history of abortion training, and (2) their willingness to participate in a study about abortion. However, the methods used have helped to capture both a wide range

of experiences and distinctions within the group. These findings teach us what such experiences mean to individuals and provide context to the study of abortion training. Most importantly, we demonstrate that given the high degree of moral sensitivity around the issue of abortion, residents benefit from being taught "why as well as how" their attendings perform abortions [11], from being granted respect for their moral boundaries around abortion care and, finally, knowing that their hard work is viewed as important and valuable to their skill development as well as to the women they serve.

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