A Descriptive Analysis of Abortion Training in Family Medicine Residency Programs

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Background and Objectives: Access to abortion services in the United States is declining. While family physicians are well suited to provide this care, limited training in abortion occurs in family medicine residency programs. This study was designed to describe the structure of currently available training and the experience of residents participating in these programs. Methods: E-mail questionnaires were sent to key faculty members and third-year residents in nine programs that have required abortion training. These faculty members and a sample of residents also completed semi-structured interviews. Results: Residency programs varied in the amount of time dedicated to the procedural aspects of abortion training, ranging from 2 to 8 days, and also in non-procedural aspects of training such as values clarification and didactics. Themes that emerged from interviews with residents included the benefit of training with respect to technical skills and continuity of care. In addition, residents valued discussion of the emotional aspects of abortion care and issues relating to performing abortions after graduation from residency. Conclusions: While the details of the curricula vary, residents in programs with required abortion training generally felt positively about their experiences and felt that abortion was an appropriate procedure for family physicians to provide. Residents emphasized the importance of both non-procedural and technical aspects of training.

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The vast majority of family physicians will have patients in need of these services, and only required training, with an opt-out option for those with moral objections, exposes all residents to the basics of counseling, procedural care and post-procedural care.

**Methods**

This study was approved by the University of California, San Francisco Committee on Human Research and conducted between August 2004 and June 2005. All 16 residency programs believed to have required abortion training, with an opt-out provision, were contacted. Eleven of these programs had previously been identified in a 2003 survey by the Group on Abortion Training and Access of the Society of Teachers of Family Medicine, and the rest were identified by experts in the field as having recently integrated abortion training.

Representatives from 13 of the 16 programs agreed to participate. The three programs that did not agree to participate either declined or did not reply to the initial mailing and multiple follow-up telephone contacts. Of the 13 agreeing to participate, nine were determined to have abortion training as a required part of their curriculum. The four programs were excluded because they offered only elective training.

Data were collected using e-mail questionnaires and semi-structured interviews. Residency program directors were first contacted to request program participation. Consent forms and e-mail questionnaires were then sent to all third-year residents and a faculty member at participating programs who was involved in abortion training.

**Questionnaire**

The questionnaires took approximately 5–10 minutes to complete and were designed to explore residents’ experiences of abortion training, the role of family physicians in providing abortion, and post-residency plans. Questions were either open-ended questions or 5-point Likert scales.

**Interview**

A subsample of residents was interviewed by phone. Residents were randomly selected from those who completed the questionnaires, and these residents were solicited for interviews by e-mail. If residents did not reply or declined interviews, more residents in that program were sequentially solicited until a sample of 25% of third-year residents in each program was interviewed or until we had attempted to contact all third-year residents in that program who had completed questionnaires. All identified faculty members were solicited for an interview. All interviews were semi-structured, lasted 20–60 minutes, and were taperecorded with the consent of the participant. The interview tapes were coded with a confidential identifier and transcribed.

**Analysis**

The questionnaire data were analyzed with Stata statistical software using two-sided t-tests. Qualitative analysis of the semi-structured interviews began with determination of the initial themes by the two interviewers. A sample of interviews was then coded by three researchers with a qualitative software program (NVIVO), using these themes as initial codes and developing additional coding. This coding scheme was discussed, and consensus codes were developed. All interviews were coded using the consensus codes.

**Results**

Of the programs included in our sample, three were from the West Coast, one from the Southwest, and five from the Northeast. Three of the programs were university based, and the remaining were community based. All but two programs were urban, with one being suburban and the other rural. All three programs that did not agree to participate were in the Northeast and located in urban locations.

Response rates to the resident questionnaire and interviews are shown in Table 1. All identified key faculty members (nine/nine) completed both the questionnaire and the telephone interview. Not all residents who replied to the questionnaire answered all questions. For the interviews, the target 25% sample of third-year residents was reached in six programs. At least two residents were interviewed in all programs, with a range of two to four interviews per program. Thirteen of the 59 residents in the survey sample and three of the 20 residents in the interview sample had opted out of aspiration abortion training.

**Description of Training**

Abortion training was generally part of a gynecology or procedure rotation. All of the programs offered first-trimester vacuum aspiration abortion training, with eight of the nine programs also providing training in medication abortion. Eight of the nine programs offered early ultrasound training.

Training occurred over 1 to 3 months, for a total of 2 to 8 days of training. Trainers were reported to be exclusively family physicians in five of the nine programs.

<table>
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<th>Questionnaire response rate</th>
<th>Integrated Programs</th>
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<td>77% (59/79)</td>
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<td>Total # of resident interviews</td>
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Other trainers include obstetrician-gynecologists, pediatricians and physician assistants.

Programs offered training in residency continuity clinics, in high-volume abortion clinics, or in both settings. Three of the nine programs integrated aspiration abortion training into the residency clinic, with all having dedicated procedure clinic sessions. In addition, five of the nine programs offered medication abortion training in the residency clinic, with three of the programs providing same-day services all or some of the time and the remaining two offering medication abortion only as part of a dedicated clinic session. Eight of the nine programs had some training provided at an off-site, high-volume clinic.

With respect to non-procedural aspects of training, residents received an average of 4 hours of didactic training, ranging from 0 to 16 hours. Only one program provided formal teaching on the practical aspects—such as malpractice issues, equipment and office needs, and legal requirements—of providing abortion services after residency. Formalized values clarification exercises, where participants explore their personal values about abortion training, were integrated in four of the nine programs, with the other programs having various degrees of informal discussion regarding the emotional and political aspects of providing abortions.

The curricula for residents who opted out of abortion training were not well defined in most programs. One program had residents meet with faculty to review a standardized didactic curriculum. In all cases, residents who were not interested in learning to perform abortions were encouraged to participate in options counseling, ultrasound, and procedural skills to the extent to which they were comfortable.

In the questionnaires, residents who did not opt out of aspiration abortion training (n=46) stated that they had already performed a mean of 31 aspiration abortions and expected to perform a mean of 47 by the end of their residency (Figure 1). The mean number of medication abortions that residents (n=48) reported performing was six. The mean number of medication abortions they expected to perform was 12, with a range of 0–56 and a standard deviation of 11.

The majority of residents reported performing only first-trimester abortions, with eight of 43 residents who responded to the question (19%) having completed abortions over 14 weeks. Thirty-three of 43 residents (77%) reported that they received training in manual vacuum aspiration, with the remainder receiving training only in electric aspiration. All but one of the 44 residents reported performing abortions using local anesthesia with a cervical block. Twenty-one of 43 residents (49%) also reported performing abortions using conscious sedation and/or general anesthesia.

Thirty-four of the 43 residents who participated in medication abortion training and responded to questions about gestational age limits (79%) had been trained to provide mifepristone/misoprostol up to 63 days’ gestation. Ultrasound was the most commonly used means of confirming completion of medication abortions, with 26 of 43 residents (60%) reporting using this method, compared to five (12%) reporting using either serial beta HCGs or ultrasound and 12 (28%) using serial beta HCGs exclusively.

**Resident Experience**

Several themes emerged from the questionnaire and interviews of residents: the value of the training within a family medicine training program, the importance of the emotional aspects of training, and the influence of training on post-residency plans.

**Value of Training.** Residents who had participated in abortion training generally felt that the experience had enriched their residency training and improved their skills as physicians. From a psychosocial perspective, residents reported that providing abortion care was consistent with the commitment of family medicine to providing continuity of care within a primary care setting.

For me, family medicine is general practice, cradle to grave and everything in between . . . Abortion is such a personal thing . . . it should be something that the patient should be able to get from their own doc in their regular office. I think it’s something we should be providing more easily, more freely, and in a comfortable place. They shouldn’t have to go to someone that they don’t know.

Just being with women as they’re going through this whole process has been a really neat part of what I’ve gotten to do . . . I would liken it to the surprise of about how much I enjoy delivering babies . . . It’s one of those poignant moments in life that I am fortunate to be a part of.

In keeping with this commitment to providing services as a part of primary care, residents with abortion training within continuity clinics reported valuing these on-site training experiences, while at the same time acknowledging the important role of training at high-volume sites.

I feel much better about it [on-site training] because I feel like I have a lot more contact with the patients, it’s much more comfortable . . . we still do our training elsewhere so we can get the numbers and feel comfortable with the procedure itself . . . So I think I see advantages to both.

Residents with on-site medication abortion training had significantly higher levels of satisfaction than those with only off-site medication abortion training, with a
mean score of 4.0 versus 3.2 ($P<.05$) on a 5-point Likert scale, with a score of 5 indicating the respondent was “very satisfied” and a score of 1 indicating the individual was “very unsatisfied.” There was a slightly higher rating of satisfaction by residents with on-site aspiration abortion training compared to residents with only off-site aspiration abortion training (4.5 versus 4.0), but the difference was not statistically significant ($P=.09$).

On a technical note, many residents who participated in the abortion training felt that their general procedural skills in gynecology improved.

Just doing that many procedures, I’m just so much more comfortable now doing everything from endometrial biopsies to inserting IUDs . . . So it was helpful to me even if I never do another abortion.

Analysis of resident questionnaires found overall support for abortion training. Seventy-eight percent of residents who participated in training reported being very or somewhat satisfied with their training. In addition, residents generally supported the concept of family physicians performing abortions. All residents surveyed assigned an average score of 4.3 on a Likert scale of 1 to 5 for the importance of family physicians providing abortions, with a score of 5 indicating an answer of “very important” and 1 an answer of “strongly unimportant.” Residents who had opted out of abortion training assigned an average score of 3.1.

**Emotional Aspects of Training.** Some residents described having conflicts around their role in abortion, while other residents experienced abortion training as no different from other aspects of their residency education. In the interviews, residents reflected on their experiences.

I think what actually influences my feelings is my own projection about what I think the woman—her own reasons—I can’t be neutral about it. If I somehow judge that the woman has a good reason for an abortion then I feel okay about it. I still haven’t worked it out. I am in process.

The first experience of viewing the tissue removed during the abortion was often described as a particularly thought-provoking moment for residents early in training and produced various reactions, ranging from anatomic interest to distress.

Many residents commented on the usefulness of being able to discuss their reactions to training in a safe environment. One residency program had a formalized weekly session where all the trainees would meet with a psychologist and debrief.

I grew up in a very [anti-abortion] environment myself and so some of the stuff I’ve heard growing up was in the back of my mind . . . But we had meetings with the psychologist and the fellows would seem to check in with us a lot. I felt supported.
In addition, many residents felt that connection to their patients and involvement in counseling assisted them in processing their experiences.

It would be nice . . . to participate [more] in counseling just to learn what issues and thoughts that the patients have to better appreciate the importance of it.

**Post-residency Plans.** Fifty-nine percent of residents (n=46) who participated in training felt they would probably or definitely provide first-trimester aspiration abortion after residency, and 68% (n=50) felt they would probably or definitely provide medication abortion services. For some residents, the exposure to abortion training and the idea that it was possible to include abortion in primary care clinics was empowering.

Prior to residency I really had absolutely no plans of ever learning abortion—but I think it was just learning about this whole first-trimester abortion and especially the medication abortions . . . it just seemed like such an easy thing to do for people in the office. So it really changed my view a lot.

In contrast, many residents felt that their training had not completely prepared them to address the practical aspects of providing abortion services after residency. The majority of residents interviewed reported that concern about logistical barriers was a factor in whether they planned to provide abortions after residency.

**Discussion**

This study found that abortion training varies among programs, especially with respect to non-procedural components of training such as values clarification and didactics. Residents were generally satisfied with the training and felt that abortion was an appropriate service for family physicians to provide. In addition, they identified program components that affected their experience of training: receiving training in continuity clinics, participating in counseling, having opportunities to process their emotional reactions, and preparation in the practical aspects of providing abortion after residency.

A major limitation of this study, however, is the small number of programs in the sample. While we attempted to survey all of the programs with required training, we only identified nine such programs. These programs may not be representative of other programs with or interested in developing abortion training.

Information obtained from the residents is also limited by difficulty recruiting residents for interviews, suggesting those residents with stronger viewpoints may have been more likely to agree to be interviewed. However, the consistency of the themes identified and the overall support for training found in the survey data suggest this is unlikely to be a large effect.

**Conclusions**

Our study results can be of use to programs interested in incorporating abortion training by providing examples of how such training is carried out. In addition, information about resident experiences can assist programs in designing curricular interventions that best meet the needs of trainees.

Residents’ focus on non-procedural aspects of training draws attention to the value of providing abortion training in a manner grounded in the values of family medicine. Family medicine training programs and the Residency Review Committee have always placed emphasis on continuity of care, the psychosocial aspects of medicine, and the role of residency programs in preparing residents for post-residency practices.8 The comments of residents suggest that abortion training that emphasizes these core values of family medicine will best meet the needs of learners.

Interviews with residents also highlighted the appropriateness of including abortion training within family medicine residency. In noting the value of providing care to patients in a potentially difficult time, ideally in a primary care setting, residents demonstrated how abortion training is consistent with the mission of family medicine—to provide continuity of care across the life cycle.

In summary, the experiences of programs with training, and of residents participating in this training, can serve as a guide to creating a successful training experience and draw attention to the value of abortion training within family medicine.

**Acknowledgments:** Data included in this paper have been presented in preliminary form at the 2005 Society of Teachers of Family Medicine Annual Spring Conference in New Orleans, the 2005 Association of Reproductive Health Professionals Annual Meeting in Tampa, Fla, the 2005 North American Primary Care Research Group Annual Meeting in Quebec City, Quebec, and the 2006 annual meeting of the National Abortion Federation in San Francisco.

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**REFERENCES**


