Integrating Abortion Training Into Family Medicine Residency Programs

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Background and Objectives: Family physicians provide many office-based procedures in primary care settings. While first-trimester abortion is a procedure appropriate for and performed by family physicians, few residency programs offer routine training in this skill. This study explored the experience of residency programs that have initiated or are in the process of initiating required abortion training. Methods: Faculty members responsible for abortion training curricula in identified programs completed questionnaires and semi-structured interviews. Results: Faculty members from nine programs with required training and seven programs interested in initiating this training were included in the study. Factors that assisted in curriculum development included the support of family medicine and obstetrician-gynecologist faculty. Commonly encountered challenges included the need for dedicated resources, inter-specialty conflict, and limited access to training sites. Conclusions: Family medicine programs can be successful at developing required abortion training. Collaboration with colleagues inside and outside the family medicine department and with receptive training sites will benefit programs interested in such training.

Providing comprehensive care across the life cycle is a core value in family medicine. The benefits of family physicians providing a broad range of services in the primary care setting include continuity and coordination of care, access for patients, enhanced physician-patient relationships, and patient satisfaction. One element of comprehensive care is office-based procedures, such as colposcopy, vasectomy, and endoscopy procedures. Both research and training guidelines have examined and encouraged the integration of these skills into family medicine residency training.

Early abortion is another skill suited to the strengths of family physicians. The non-procedural aspects of abortion care, including counseling and the ability to provide contraceptive information, are standard in the practice of family medicine. With respect to aspiration abortion, procedures such as endometrial biopsies and IUD insertions are commonly performed by family physicians, and limited additional training is needed to perform first-trimester abortions for those proficient in these skills. Aspiration abortion is recognized as within the scope of practice for family physicians, with terminations up to 10 weeks gestation listed as an advanced skill by the American Academy of Family Physicians. Medication abortion using mifepristone and misoprostol is also well documented to be in the scope of practice for family physicians.

In contrast to the procedures mentioned above, however, aspiration and medication abortion training in family medicine residency programs has received limited attention, and few programs offer routine training (with opt-out provisions and alternative curricula for those residents who do not wish to participate). A 2003 survey by the Society of Teachers of Family Medicine (STFM) Group on Abortion Training and Access found that only 11 of the 480 residency programs in existence...
at that time were willing to be identified as offering abortion training as a routine part of the curriculum.\textsuperscript{15} This relative neglect of training is likely related to several factors. First, procedural training in family medicine residency programs generally presents a range of challenges, including the availability of trained faculty, limited procedural volume, competition with other specialties, and the need for expensive equipment.\textsuperscript{16} In addition, training in abortion likely presents unique challenges due to its politically charged nature. Little research, however, has examined the specific experiences of residency programs in abortion training.

Two recent articles have described the experience in individual institutions in initiating training for medication abortion.\textsuperscript{17,18} Both programs described challenges in the process, including resistance from staff, the need for equipment such as ultrasound units, and the need for surgical back-up. Ultimately, both programs were successful in integrating medication abortions, and their reports present strategies they used to overcome challenges, including collaboration with other departments and values clarification sessions with staff. Another recent paper explored the experiences of seven programs in establishing abortion training and services in primary care residency clinics.\textsuperscript{19} Identified themes included the importance of institutional support, back-up agreements with obstetrician-gynecologists, and ensuring patient volume.

While these initiatives are important first steps, the aforementioned papers only describe the experience of two individual programs and a local consortium and only explore training within residency continuity clinics. Our study was designed to identify the challenges and facilitators to establishing routine abortion training across a national sample of family medicine residency programs, including programs that trained both within and outside the residency continuity clinic. To explore a diversity of experiences, we studied both programs that have already been successful at implementing abortion training and programs that are in the process of developing this training.

**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 of the 16 residency programs across the United States believed to have a required abortion curriculum (with an opt-out provision) and seven US programs in the process of developing this training were contacted. Eleven of the programs with required training had previously been identified in a survey performed by the STFM Group on Abortion Training and Access,\textsuperscript{15} and the other programs were identified by experts in the field.

Program directors in these 23 programs were invited to participate and asked to identify key faculty members in this curricular area. Consent forms and e-mail questionnaires were then sent to these faculty members. The questionnaires took approximately 5–10 minutes to complete and included general information on abortion curricula, including the specialty of abortion trainers. All identified faculty were then contacted for telephone interviews. Interviews were semi-structured, lasted 20–60 minutes, and were tape-recorded with the consent of the participant. The interview tapes were coded with a confidential identifier and transcribed.

Our study sample ultimately consisted of 16 of the 23 programs contacted. Of the 16 programs initially categorized as having required training, three programs either declined to participate or did not reply to the initial mailing and multiple follow-up telephone contacts, and four programs were determined to not have required training, leaving nine for analysis. All of the seven programs without required training agreed to participate.

Qualitative analyses 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 NVIVO software, using these themes as initial codes and developing additional coding. This coding schema was discussed, and consensus codes were developed. All interviews were coded using the consensus codes. Data analysis of the quantitative survey data was conducted using Microsoft Excel and chi-square statistics.

**Results**

Characteristics of programs in the study sample are described in Table 1. All programs had routine aspiration abortion training, and eight of the nine had routine medication abortion training. Three programs reported having required abortion training for 2 years or less, and six programs reported training for 5 to 20 years.

**Curriculum Development in Programs With Required Training**

Several factors were noted to influence the process of developing required abortion curricula (Table 2).**Intra-departmental Factors.** All of the nine programs with required training had faculty “champions” who were influential in the development of the abortion training curriculum. All were motivated by a commitment to improve both the training of residents and access to abortion services for patients. In addition to spearheading curriculum development, they provided abortion services and functioned as trainers. These key faculty members also noted the importance of having support from other family medicine colleagues:
I think that the strong commitment of a couple faculty members is critical...a couple of very strongly supportive, committed people...who are actually willing to put time, and energy...is real, real critical.

Other obstacles...were individual faculty members who were resistant to the idea of providing abortion care. We had by far, you know, support. It was only really two people...But the chair was very supportive, and a number of other vocal advocates...really helped us.

Residents were also influential in the process of developing several programs. One faculty member described their involvement:

They were involved from an advocacy perspective, saying they wanted this to happen, they wanted the [abortion] training.

In programs where residents were less uniformly supportive, actively including residents in curriculum development was noted to be important in fostering their ownership of and participation in the training:

I think if we had to do it all over again, we would have included the residents earlier in our discussions...eventually everything worked out well, but if I were counseling any residency about taking this on, it would be with complete openness and transparency from the very beginning.

The majority of respondents stressed the importance of resources and time allocated to support the development of abortion training. These resources, from the department and/or outside organizations, were critical to defray both initial and ongoing costs of training. Initial costs included the purchasing of supplies for providing abortions at residency continuity clinics, such as ultrasound machines and manual vacuum aspirators, and financial support of faculty time. Compensating high-volume sites for the costs of providing training was the most frequently mentioned ongoing cost.

All programs in the process of including abortion training within residency continuity clinics noted that clinic staff buy-in was extremely important. Involving clinic staff in the process of developing the curriculum helped to engage them. Faculty in programs where members of the support staff were not initially supportive noted that workshops for “values clarification,” in which participants explore their personal values about abortion training, were helpful in improving support and interest.

Interdepartmental/Hospital Factors. The majority of faculty members stated that their relationship with colleagues in the departments of obstetrics and gynecology had facilitated their efforts to expand abortion training, and several described this assistance as critical to their success. Ways in which obstetrician-gynecologists improved the process included assisting with logistics, such as clinical protocols and medication ordering, training family medicine faculty, offering political support within the community and/or hospital, and providing aspiration or surgical back-up.

### Table 1

**Characteristics of Programs**

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<th>Characteristic</th>
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<th>Programs Without Required Training (n=7)</th>
<th>Programs That Declined to Participate (n=3)</th>
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### Table 2

**Factors Affecting the Development of Abortion Training**

**Intradepartmental factors**
- Faculty champion
- Family medicine faculty
- Residents
- Dedicated resources
- Support staff

**Interdepartmental/hospital factors**
- Relationship with obstetrics-gynecology colleagues
- Credentialing

**Non-institutional factors**
- Accessible high volume abortion clinic for training
- Community reaction
One faculty member’s relationship with obstetrician-gynecologist colleagues was summarized in this quote:

We really have to give credit completely to the fact that we’ve had a long-time OB-GYN on our faculty, who has a lifelong commitment to reproductive rights. [He] is really the person who trained me . . . So it really is [this OB-GYN] who has brought that into the residency . . . [and] by me becoming trained it really helped kind of send a message that this isn’t just a thing an OB-GYN does.

The relationships with obstetrician-gynecology colleagues also presented challenges in some programs. Highlighting the complexity of the relationships with obstetrician-gynecologists, half of the programs that reported support from individual obstetrics-gynecology colleagues also reported some degree of resistance from the obstetrics and gynecology department. The most common source of resistance arose from issues around surgical back-up.

Requirements for credentialing to provide aspiration abortions or perform first-trimester ultrasounds within residency continuity clinics varied across programs. In a few programs, family medicine department chairs determined credentialing without involvement of a hospital credentialing committee, and in one case, first-trimester abortion was already included in the core privileging of family medicine faculty. In other departments, credentialing involved the agreement of the departments of obstetrics and gynecology and/or radiology, which created various degrees of difficulty. Significantly, since all residency programs had preexisting broad malpractice coverage, malpractice insurance was not noted to be a barrier in any program.

Non-institutional Factors. Most of the programs had at least some of their training provided at high-volume abortion sites, which were neither university nor hospital affiliated. Several faculty members noted that this relationship was necessary to provide training, especially when no abortion services were provided within their hospital or clinic system.

A few programs were located in communities in which there were objections to the provision of abortion services. Tension was manifested in a variety of ways, including protestors outside one hospital and resistance from the board of one community clinic where residents provided primary care. The training of residents was not noted to be a specific source of controversy beyond that engendered by introducing abortion services. Several faculty members noted that it was easier to incorporate abortion services into their clinics when they were administered by the hospital or university system than when they were community governed.

Challenges for Programs in the Process of Developing Required Abortion Training

The experiences of programs not yet successful in integrating required abortion training were compared to already successful programs. Of note, integrated and non-integrated programs were similar in certain key areas. All programs had a faculty advocate dedicated to promoting abortion training. In addition, rates of resistance from obstetrician-gynecology and family medicine colleagues were no different between the two types of programs. There were also no specific concerns about malpractice or credentialing in non-integrated programs.

Several differences were noted between these two groups. The percentages of family medicine faculty providing abortions were markedly different, with an average of 17% of all faculty providing abortions in programs with required training, compared to only 4% in programs without required training (P = <.05). Several of the programs with required training reported having an obstetrician-gynecologist who played a crucial role in developing their curricula, while none of the other programs had this type of an advocate. Faculty in programs without required training also reported that a lack of resources, including the funding necessary to buy an ultrasound machine and to support faculty time, was a significant challenge. Finally, the majority of programs not yet successful at initiating required training reported that lack of access to high-volume practices was a barrier. In several cases, both obstetrics-gynecology and family medicine residency programs depended on a limited number of training opportunities for residents.

Discussion

The experiences of programs included in this study may help other programs interested in integrating abortion training to anticipate and address challenges in developing their training curricula. Expanding the number of programs with abortion training is increasingly important, since access to abortion services in the United States is limited and declining. Between 1996 and 2000 alone, there was an 11% drop in the number of abortion providers.20 Because an estimated 40% of all women will have at least one abortion,21 this declining access has the potential to affect women in every family physician’s practice. Family physicians are particularly well suited to address this problem, since they often provide services in geographic areas with limited access to medical services.22 In addition, while not all residents who participate in this training will become abortion providers, being exposed to this training has the potential to improve both their counseling skills and their facility with other reproductive health procedures, including ultrasound examinations and IUD placements.
Many of the challenges noted by faculty members, such as access to adequate procedural volume and the need for dedicated resources, are similar to those described previously by others for procedural training in general. As expected, abortion training also presents unique issues due to its political and social context. To overcome both the common and unique challenges, two prominent program features were identified: the presence of a faculty advocate and an emphasis on collaboration, both within family medicine departments and with outside parties.

The presence of a dedicated faculty champion was the most universal finding in our study. While most curricular changes in residency programs require some advocacy by individuals within the program, the controversial nature of abortion makes the commitment of these individuals even more important. Previous studies of abortion training have documented that these faculty leaders often benefit from protected time and resources for activities such as educational interventions and values clarification discussions with staff, faculty, and residents.

With respect to intradepartmental collaboration, faculty reported that other family medicine faculty who supported the provision of abortion promoted a positive environment around these services. While causality was not determined, the increased number of abortion providers in family medicine programs with required training suggests that having other faculty members committed to providing abortion services furthers the success of these efforts.

Family physicians and obstetrician-gynecologists both contribute to the availability of abortion services in this country, and the interaction between the two departments was noted to be crucial by faculty developing the training. Family medicine and obstetrics and gynecology departments should work together to maximize use of available training sites for both specialties and to facilitate development of training programs. Clearly, this collaboration is in the interest of both specialties and the promotion of women’s health.

The relationship between residency programs and outside training sites is an issue particular to abortion training, compared to other procedures, because of the unique manner in which abortion services are delivered in this country. Most procedures can be taught within the institution in which the residency is based. In contrast, abortions are often provided in freestanding clinics, with more than 93% of abortions occurring in such sites in 2002.

Therefore, many programs may have difficulty identifying an abortion clinic interested in training or with time available for training. Because most freestanding abortion clinics do not have funding earmarked for training, residency programs should consider providing incentives for these clinics to train residents.

**Limitations**

The limitations of this study include the small number of programs and individuals included. While we attempted to survey all programs with required training, and nine of the 12 programs participated, these programs may not be representative of the experiences or barriers faced in other programs, especially those less interested in abortion training or in geographic areas less supportive of abortion training. Since the majority of our programs were based in urban locations, rural programs specifically may face different challenges.

**Conclusions**

Despite encountering challenges, some family medicine residency programs have successfully implemented required abortion training. Programs interested in developing this training will benefit from a carefully planned approach, with attention to collaborating with family medicine and obstetrician-gynecologist colleagues, developing relationships with training sites, and involving residents and staff in the process.

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**References**