Being in the Room: Reflections on Pregnancy Options Counseling During Abortion Training

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Background and Objectives: *The Residency Review Committee requires that family medicine residents learn options counseling for women with unintended pregnancies. This qualitative study identifies important domains for future formal evaluations of pregnancy options counseling by exploring the relevant benefits reported by residents who underwent routine abortion training. To our knowledge, this is the first study of abortion training in family medicine to include an in-depth examination of its benefits in areas that may be important for pregnancy options counseling.* Methods: *Residents from two urban family medicine residency programs received training in first-trimester aspiration abortion at a high-volume abortion clinic during a routine women's health rotation. Thirty-minute semi-structured interviews were conducted with all 28 residents who rotated between July 2005 and November 2006. A coding scheme was developed and applied to transcripts for analysis.* Results: *Through exposure to routine abortion training, residents reported improved knowledge, attitudes, and skills that are likely to be important for providing open and informed pregnancy options counseling. These include an understanding of the context of women's lives when they seek abortion care, familiarity with the procedure, and improved self-reported pregnancy options counseling skills.* Conclusions: *Our findings suggest that exposure to abortion training benefits residents in areas that may be important for providing effective pregnancy options counseling. In addition, residents' reflections on their involvement with patients during the abortion process highlight key domains for future formal evaluations of accurate and nonjudgmental options counseling for unintended pregnancy.*

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In the United States, nearly half of pregnancies are unintended, and 40% of these unintended pregnancies end in abortion.[1] As a result, family physicians, who often make the diagnosis of pregnancy for their female patients, should be knowledgeable about women's pregnancy options, including abortion.

The Residency Review Committee (RRC) requires that family medicine residents learn to provide options counseling for women with unintended pregnancies, stating that, "All residents must be trained to competency in…options counseling for unintended pregnancy."[2] We hypothesized that observing abortion procedures might benefit residents in areas that would be helpful for providing accurate and nonjudgmental options counseling for unintended pregnancy.

Past studies have shown that only a small percentage of family medicine residency programs offer training in abortion care as a routine experience.[3-5] Recently, a growing number of programs have integrated routine training in first-trimester aspiration and/or medication abortion into their standard curriculum.[6-11] Most educational evaluations of abortion training in family medicine have primarily focused on procedural skills and intent to provide abortions as outcome measures.[8,12,13] However, quantitative findings,[8,9,12] resident comments,[9] and the experience of educators[7,14] point to the potential effect of abortion training on pregnancy options counseling skills. Nothnagle et al write, "In our experience as trainers, all residents, including those who identify themselves as strongly anti-abortion, are better able to deal with these ethical conflicts and support patients' decision making in a more balanced, unbiased manner after participating in a comprehensive reproductive health curriculum that includes abortion care."[14]

The present study includes residents' reflections on their involvement with patients during the abortion process and describes its impact on residents' comfort with providing accurate and nonjudgmental options counseling for unintended pregnancy. To our

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knowledge, this is the first study of abortion training in family medicine that includes an in-depth examination of resident-reported benefits in areas that may be important for options counseling.

Methods

Overview

We conducted an exploratory study examining residents' evaluation of abortion training at a single high-volume abortion clinic for 28 family medicine residents from two urban residency programs. Our sample included both residents who participated in hands-on abortion training and those who opted out of these components of training. During semi-structured interviews, we asked residents about their experience with abortion training, including prior exposure to abortion, surprises encountered during training, skills learned in addition to abortion provision, and the influence of training on their attitudes and future practice (Table 1). Specifically, we explored the benefits residents reported in domains related to pregnancy options counseling, with an emphasis on both the technical and psychosocial aspects. Residents provided oral consent, and the study was deemed exempt from formal review by the Montefiore Institutional Review Board.

Participants

A total of 28 residents from two urban family medicine residency programs received training in first-trimester manual and electric vacuum aspiration abortions at a single high-volume abortion clinic during a routine women's health rotation. Although residents often gained additional exposure when women received abortion care at their family medicine continuity clinics, this report focuses primarily on training at the high-volume clinic.

Table 1

Topics Addressed in the Interview Guide:

- Overall experience of training
- Prior exposure to aspiration abortion
- Anything that surprised them the first time they observed/performed an aspiration abortion
- Most helpful/educational elements of training
- Aspects of training that need improvement
- Comparing this training to other educational experiences in residency
- Other skills learned besides abortion (with prompts, including options counseling)
- Their choice to perform or only observe abortions
- Attitudes before and after training
- Stories women told them while observing/providing abortions and impact
- Impact of abortion training on future practice
- Thoughts on having abortion training as routine
- Other comments

Training at the High-volume Abortion Clinic

At the high-volume abortion clinic, residents shadowed a patient throughout the entire process, including observing pre-abortion counseling conducted by a counselor. Residents also performed sonography, and most received hands-on training in manual and electric vacuum aspiration abortions using local anesthesia. Residents who chose not to participate in the hands-on abortion training met with faculty to create an individualized learning experience. Ultimately, most opted to observe procedures (Table 2). In addition to developing procedural skills, residents had the opportunity to learn about the broader psychosocial context of abortion care by hearing women share their stories in pre-counseling sessions and conversations during the procedure.

Sampling Method and Data Collection

All 28 residents who completed their women's health rotation between July 2005 and November 2006 at the two residency programs agreed to be interviewed. Thirty-minute semi-structured interviews were conducted by one interviewer between June 2006 and March 2007. The interview guide was pilot tested and modified prior to initiating this study. Interviews were arranged and conducted in person by a trained research assistant who was otherwise uninvolved with the residents. Interviews were electronically recorded, coded with a number to maintain confidentiality, and transcribed by a professional service.

Qualitative Data Analysis

The study team was composed of a research assistant, a qualitative research consultant, and two family physicians involved in the abortion training. The study team was intentionally comprised of both individuals involved with the training and those with no prior involvement, in recognition of the influence researchers bring to the analysis.

After three of the researchers reviewed all of the transcripts and the qualitative consultant reviewed a selection of transcripts, the study team developed an initial thematic coding system. A sample of the interviews was then coded separately by three researchers

Table 2

Training at the High-volume Abortion Clinic

	Sonography and Hands-on Abortion Training	*Sonography and Observation of Abortions Only*	*Sonography Only*	*Total*
# of residents	22	5	1	28

using the initial codes. The study team compared coding, refined initial codes, developed additional ones, and disagreements were resolved through discussion until a set of consensus codes was reached, and reliability of coding was confirmed. We applied the coding scheme to transcripts using a qualitative software program (NVIVO) and analyzed salient themes. We used an editing approach to develop the analysis.[15]

Results

The interviews revealed how exposure to routine abortion training provided residents with benefits in areas that might help them provide open and informed options counseling for unintended pregnancy. The three components relevant to options counseling that emerged from the interviews are: understanding the context of women's lives when they seek abortion care, gaining familiarity with the procedure, and improving self-reported options counseling skills.

Theme 1: Contextualizing Abortion

Through their abortion training experience, residents learned about the diversity of women seeking abortions and the many reasons why women have abortions. One resident expressed this common theme:

> It [the abortion training] gave me an opportunity to see the range of different types of people coming to get an abortion…and the different reasons that people might have for it and the different circumstances in which they're living.

Another resident similarly stated:

> It's interesting just to…see where everyone's coming from and…makes you more aware of how you should not have assumptions about, you know, people, their stories and their lives and the choices that they make.

When asked to reflect on the stories they heard from women seeking abortion care (Table 3), residents seemed most influenced by the wide range of women seeking an abortion and the many reasons behind that choice. As one resident said:

> There's the story of a woman who just had a kid 8 months ago…There's the woman with eight kids who just can't afford another one...There's the woman who just got engaged and really would like to have had a child, but…[isn't] able to care for a child at this point in time…There's a million and one stories...none of them less engaging than the other.

Residents discussed the effects of learning why women have abortions on their own attitudes toward abortion, both in terms of confirming and challenging prior beliefs. One resident said:

> I was pretty open to abortions before. But I think that it definitely gave me a lot more insight into why people do it.

Another resident stated:

> It really dispelled a lot of beliefs that…it's being used as a form of birth control, which…is a myth that gets propagated a lot.

Finally, a few residents discussed how their training experience transformed an issue from the theoretical and grounded it in reality. One resident described:

> You talk to these women, and they always have their story. It really makes it really real. Which…makes it harder…to have these sort of theoretical discussions about abortion, because you feel like these other people haven't been in the room with this woman who is crying and says I just can't have another child.

Theme 2: Familiarity With Procedure

Because nearly all residents either participated in hands-on abortion training or observed procedures, residents gained basic familiarity with the procedure, which often challenged previous misconceptions. This training experience provided the majority of residents with their first exposure to a first-trimester aspiration

Table 3

Stories Residents Heard From Women Having Abortions

• She already had three children…She was barely able to make it taking care of all the children that she had already…she knew that financially they weren't going to be able to support that child. And they didn't want to have the child and then give the child up for adoption, and there was no one else in the family to take care of the child.
• We had people who were 14 who weren't ready to have a child. We had people who were like 35 and weren't ready to have a child.
• There were a number of women who…were high school students…[and] had to get back and study for their finals…a few things struck me... how young they were…how they got in this situation…and how resilient they could be.
• It was kind of a domestic violence issue. So that was kind of the big issue was that it was her boyfriend, but it was also a product of rape and violence as well.
• I heard about women who have a number of children, and they've had problems with the last pregnancy, they don't feel as if they want to go through another pregnancy because it may be health problems related to that.
• A few women who were actually older women had thought they were post-menopausal until they got pregnant. Which is an interesting scenario that I think we don't normally think about older women, really women in their 40s having terminations.

abortion in an ambulatory care setting using a manual vacuum aspirator (MVA) with local anesthesia. A few residents remembered having previously observed abortions in the operating room under general anesthesia. One resident said:

> I had this misconception that people would be under general anesthesia because…in medical school, they did do some terminations, but it was under general anesthesia…so…this was definitely a new experience.

When asked about surprises during their abortion training experience, the most common response was residents' surprise at the speed and simplicity of the procedure. One resident noted:

> It was surprising that it was such a simple procedure, that it was so easy to do.

Another commented:

> There's so much buildup in the media and everything about this procedure. And when it really breaks down to it, it's just 10 minutes in the office.

A few residents explicitly acknowledged that they had assumed the procedure would be more complex or take longer before their training experience. One resident said:

> For some reason I just thought it would be—it would just take a lot longer.

Another explained:

> The ease of the technique was more surprising than anything. I thought it would be a lot harder.

In addition to their surprise at the simplicity of the procedure, a handful of residents expressed surprise at how well patients tolerated the procedure. By gaining a more accurate understanding of the procedure, residents may be more comfortable describing it to patients, as discussed below.

Theme 3: Effect on Counseling Skills

The vast majority of residents believed that their abortion training experience improved their pregnancy options counseling skills, especially in terms of anticipatory counseling to women considering an abortion. Although some residents mentioned that observing the counseling sessions was helpful, residents primarily attributed their learning to being in the room and observing and/or participating in procedures. Notably, this educational outcome was reported by residents who had varying clinical experiences: some who observed procedures only, some who participated minimally in procedures, and some who participated fully.

When asked about the most educational or helpful parts of the training, a resident who only observed answered:

> I think learning about the actual abortion procedure itself, about what is done until like what week time period, just so patients know what to expect and what things will feel like and what they'll observe and what they won't see and so on. Just so you can give them a bit of guidance and counseling before they go in.

Another resident who participated in a few procedures but primarily observed procedures said:

> Before I didn't even know what to really tell my patients… I have learned what at least to say to my patients if they ask me…how long does it take, is it painful? You know, those simple questions that patients will ask…You know when you read something and you see something it's totally different? So now I feel…confident about what I'm saying rather than just reading it out of a book.

A resident who fully participated in hands-on abortion training said:

> I definitely feel more comfortable with options counseling…having done [the] full spectrum…doing a few deliveries and coupling that with the experiences I had doing terminations, and they're both equally emotional experiences for different reasons. And for the most part women…are clear about you know why they made the decision…[and] end up being OK either way. That has made me a little more empathetic…in terms of counseling a patient.

In considering the effect of this training on their future practices, a common theme emerged among residents who were unsure of their future plans to provide abortions or did not intend to provide them. Specifically, many asserted that their experience would help them be better options counselors. One resident expressed:

> I won't be performing abortions, but I would counsel patients…one of the good things about…[the training] is that you…can tell them [patients], this is what happens with the suction abortion. This is what happens with a medication abortion.

Another resident who does not anticipate providing abortions said:

> I want to be an effective counselor… I'm happy I realized that a diagnosis of pregnancy has different

> meanings for different people. And evaluating what the pregnancy means for our patients is important. And not assuming, yes this [pregnancy] is something that you will all want to be happy about and…continue, because not every patient does obviously. So, making that a priority for the rest of my career will be important.

Discussion

Through participation in routine abortion training, family medicine residents reported benefits in domains that may be important for pregnancy options counseling, a potential outcome of abortion training that has not previously been explored in depth. Specifically, our findings identify key areas of knowledge, attitudes, and skills in which training may help residents provide open and informed options counseling for unintended pregnancy, an important RRC requirement.

Residents learned firsthand the many reasons why women seek abortions. Hearing women's stories deepened residents' understanding of the psychosocial context of abortions, enhancing their ability to empathize with patients and provide nonjudgmental options counseling. Because nearly all the residents chose to observe or participate in first-trimester aspiration abortions, they discovered that it is a simple and quick procedure, knowledge they can use to accurately describe the procedure to potentially anxious patients. Finally, residents stressed their increased commitment and ability to provide detailed options counseling based on their personal experience with procedures.

As noted previously, the abortion training experience offered the majority of residents their first exposure to first-trimester aspiration abortions in an outpatient setting using local anesthesia. Moreover, abortion is often popularly portrayed as a surgical procedure that is complex and challenging. Residents' surprise at the simplicity and speed of aspiration abortions revealed their previous misconceptions that the procedure would be technically difficult and lengthy. In addition to learning about the technical aspects of aspiration abortion, residents also learned about the broader psychosocial context of abortion. Significantly, these findings held true for residents who had ambivalent feelings about abortion, including those who opted out of hands-on training.

Limitations

This study has several limitations that should be considered when interpreting the results. First, because this study reflects the experience of two programs with routine abortion training in a single urban setting, there may be limits to the generalizability to other settings. Nonetheless, although no residents espoused definitively anti-choice views, residents exhibited a wide range of comfort levels with abortion.

Second, though confidentiality was assured, residents may have felt inclined to provide positive feedback regarding their experiences. To minimize this, the interviews were intentionally arranged and conducted by a research assistant who was not involved with the residents in any other way.

Third, because nearly all residents observed or participated in procedures, we did not compare their experiences to those of residents without any abortion training exposure. Future studies could formally evaluate pregnancy options counseling skills among residents in programs without abortion training using the key domains we have identified.

Conclusions

Despite these limitations, our study highlights the potential benefits of having family medicine residents observe or participate in first-trimester aspiration abortions in the outpatient setting as part of their training. Because only interested residents will seek out elective training, routine training increases the likelihood that all residents, even those with ambivalent feelings about abortion, may have some exposure to the procedure. Being in the room to observe or provide abortions can dispel assumptions and misinformation, so that residents can provide accurate and nonjudgmental guidance to patients.

The majority of residents in our study expressed strong support for routine training, with several emphasizing the importance of routine training for developing options counseling skills. Our findings suggest that exposure to abortion training benefits residents in areas that may be important for providing effective pregnancy options counseling. In addition, residents' reflections on their involvement with patients during the abortion process highlight key domains for future formal evaluations of accurate and nonjudgmental options counseling for unintended pregnancy.

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References

1. Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. Perspect Sex Reprod Health 2006;38(2):90–6.
2. ACGME Board. ACGME program requirements for graduate medical education in family medicine. www.acgme.org/acWebsite/downloads/RRC_progReq/120pr07012007.pdf. Accessed December 15, 2008.
3. Steinhauer JE, Depineres T, Robert AM, Westfall J, Darbey P. Training family practice residents in abortion and other reproductive health care: a nationwide survey. Fam Plann Perspect 1997;29(5);222-7.
4. Talley PP, Bergus GR. Abortion training in family practice residency programs. Fam Med 1996;28(4):245–8.
5. Lesnewski R, Prine L, Gold M. New research abortion training as an integral part of residency training. Fam Med 2003;35(6):386–7.
6. Bennett IM, Aguirre AC, Burg J, et al. Initiating abortion training in residency programs: issues and obstacles. Fam Med 2006;38(5):330–5.
7. Dehlendorf C, Brahmi D, Engel D, Grumbach K, Joffe C, Gold M. Integrating abortion training into family medicine residency programs. Fam Med 2007;39(5):337-42.
8. Paul M, Nobel K, Goodman S, Lossy P, Moschella JE, Hammer H. Abortion training in three family medicine programs: resident and patient outcomes. Fam Med 2007;39(3):184–9.
9. Nothnagle M. Benefits of a learner-centered abortion curriculum for family medicine residents. J Fam Plann Reprod Health Care 2008;34(2):107-10.
10. Leeman L, Espey E. "You can't do that 'round here": a case study of the introduction of medical abortion care at a university medical center. Contraception 2005;71(2):84-8.
11. Prine L, Lesnewski R, Bregman R. Integrating medical abortion into a residency practice. Fam Med 2003;35(7):469-71. (*Note: In the article, training is described as voluntary. However, the authors note that it has since become fully integrated as routine.)*
12. Bennett IM, Johnson M, Wu JP, et al. A family medicine training collaborative in early abortion. Fam Med 2007;39(3):164-6.
13. Brahmi D, Dehlendorf C, Engel D, Grumbach K, Joffe C, Gold M. A descriptive analysis of abortion training in family medicine residency programs. Fam Med 2007;39(6):399-403.
14. Nothnagle M, Prine L, Goodman S. Benefits of comprehensive reproductive health education in family medicine residency. Fam Med 2008;40(3):204-7.
15. Crabtree BF, Miller WL, eds. Doing qualitative research. Newbury Park, Calif: Sage Publications, 1992.