# An "Invaluable Skill": Reflections on Abortion Training and Postresidency Practice

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**BACKGROUND AND OBJECTIVES:** The goal of this study was to explore family medicine residents' experiences with abortion training and identify positive and negative influences, and facilitators and barriers to providing abortion care.

**METHODS:** We conducted a qualitative study of recent graduates of an urban family medicine residency in the Northeast United States with an opt-out abortion curriculum. Individual recorded interviews were conducted with two classes of graduated residents until data saturation was reached. Data were coded and interpreted by both authors using the template analysis method.

**RESULTS:** Twenty residents completed interviews. Most trainees had limited or no abortion exposure prior to residency but were open to learning abortion care. By graduation, residents reported confidence in providing options counseling for unintended pregnancy. Overall, residents felt more comfortable providing medication abortion than aspiration abortion. Many reported feeling less emotional reaction to medication abortion and noted more technical and logistical barriers to learning aspiration abortion. Logistical barriers impede integration of medication abortion into practice for many, but were perceived to be less difficult to overcome than barriers to aspiration abortion integration. All participants agreed abortion care fits into the scope of primary care. Due to a variety of barriers, few of those who had not previously planned to become abortion providers after graduation incorporated it in their practice.

**CONCLUSIONS:** Abortion training prepared residents to counsel women with unintended pregnancy, but numerous barriers inhibit integration of abortion care into practice. Given limited abortion training resources and fewer perceived barriers to medication abortion provision, family medicine residencies may consider focusing training on medication abortion.

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One in three women in the United States will have an abortion in her lifetime.[1] Despite the high prevalence of abortion, access for many American women remains limited.[2] As of 2014, 39% of reproductive-age women lived in counties without an abortion provider.[1] Family physicians often work in rural and underserved communities where need for abortion providers is greatest, and are well positioned to fill the provider gap.[3]

In 2018 at least 34 of over 600 nationwide family medicine residencies have successfully implemented abortion training, an increase from prior years.[4] These programs are well received by residents.[5-8] Despite an increase in training, the provider gap remains. Factors that facilitate or deter abortion provision are not well understood. This study explores recent family medicine graduates' experiences in an opt-out abortion curriculum. We aimed to identify factors influencing resident plans regarding abortion provision after graduation. Describing enablers of and barriers to abortion may help programs tailor curricula to increase the number of graduating abortion providers.

## Methods

We conducted this study at a family medicine residency in the urban Northeast United States where residents participate in opt-out abortion training. The hospital's institutional review board approved the study and participants were provided written informed consent. We conducted individual phone interviews with two classes of former residents within 18 months following graduation. Interviews focused on curriculum quality, emotional responses to training, technical skill, and the spectrum of care graduates plan to provide.

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Interviews were recorded, transcribed, and deidentified. Coding was done with the aid of spreadsheet software. Coded data was analyzed using template analysis.[9] Authors collaboratively created a template after reviewing the first four interviews and revised it after separately reviewing the remaining interviews to include novel themes and subthemes. All interviews were recoded to incorporate changes, and coding discrepancies were resolved through discussion. All interviews were reanalyzed to identify higher-order interpretations and overarching themes.

## Results

Of 26 graduates in 2014 and 2015, three opted out of abortion training and were excluded from this study. Data saturation was reached when 20 of the remaining 23 graduates completed interviews, and recruiting was discontinued. All invited graduates agreed to participate. Interviews averaged 30 minutes in length. Most participants reported no exposure to abortion before residency but were open to participating in abortion care. Seven participants entered training with desire to provide abortions. Graduates were working in a variety of settings at time of interview: five were affiliated with residency programs, seven in group private practice (one of whom held a part-time appointment within a residency), four at federally qualified health centers, one with Indian Health Service, one hospitalist and two solo practitioners.

Graduates generally felt positive about their abortion training. Participants found the experience rewarding, reporting, it "felt really good that I made a positive contribution to somebody's life." Perceived training benefits included feeling they had learned an "invaluable skill" that enhanced counseling and gynecologic procedure skills. All participants agreed abortion is within the scope of primary care. Although eight graduates planned to provide abortion after graduation, only three were providing when interviewed, and all were affiliated with a residency program.

Participants cited emotional and logistical barriers as contributors to their plans. Emotional barriers were "really difficult" for many. One graduate explained, "I kind of felt like I was very steadfast. Then I was surprised that I was questioning things, and although it is totally appropriate to question things, I didn't think I was going to." Conversely, a positive emotional influence was the desire to provide continuity of care for patients. Several expressed that "it would be great to be able to do this for my own patients" and that training "reinforced how important it is to be able to incorporate abortion into… my own primary care practice."

Logistical barriers fell into two categories: institutional and technical. Institutional barriers comprise difficulties with practice integration. Graduates in the public sector echoed, "the political climate and kind of state and federal laws about who can [provide abortions] and when and how…that's definitely like a huge barrier." Others in private practice lamented "the practicalities of setting everything up" and "the politics of whether or not workplaces will allow me to incorporate [abortion] into my practice." Perception of technical skill was strongly tied to procedure volume; one resident expressed, "I'm hoping [to] get a little bit more experience before I graduate…I will probably not feel comfortable being independent on [aspiration abortion] right out of residency." Participants who felt technically competent to provide had obtained training outside the normal curriculum.

When asked if plans to provide medication or aspiration abortion differ, graduates felt medication abortion was "simple and medically easy," not requiring advanced technical skills. One participant recalled, "after the first session I felt that I was able to counsel and provide medication abortions." Graduates viewed institutional barriers as less burdensome, and medication more than aspiration abortion as "something that can easily be incorporated in any kind of practice." Emotional barriers were less prohibitive; graduates were "surprised with how *not* emotional" medication abortion was, whereas aspiration abortion was "powerful." One graduate described the contrast: "I mean you felt more active in [aspiration abortions] and so that was a little bit more of an intense experience." While only eight graduates planned to provide abortions, most others could see themselves adding medication abortion to their practice under the right circumstances.

## Discussion

In this qualitative study of opt-out abortion training at a single family medicine residency, most graduates remain open to providing abortion, though few plan to provide. However, all participants view the curriculum as a valuable experience. Training enhances clinical skills and overall comfort caring for women with unplanned pregnancies. Both personal and logistical barriers contribute to graduates' decisions on scope of practice. Graduates more often envision themselves providing abortion when institutional barriers are reduced, when abortion is integrated into primary care and for medication abortion alone. Reported barriers and enablers align well with those identified in previous research.[5,7,10-13]

Generalizability of our results is limited by the small sample size and single site. Despite our small sample, data saturation was easily reached. As many family medicine abortion training programs are in similar demographic areas, our findings are likely applicable to this cohort of programs.[13] Additionally, when talking about a politically charged topic such as abortion, participants may not fully disclose their feelings. While interviews appeared candid, social desirability bias remains plausible. However, there is fidelity in our results when compared to similar research. In a 2015 study by Romero et al, perceived competence was

positively associated with intention to provide, as was number of procedures performed.[13] In a 2011 study, graduates of reproductive training programs were, like the graduates in our study, more likely to provide medication abortion compared to aspiration abortion.[14]

Low recruitment of new abortion providers, while not surprising, was nonetheless disheartening. However, two hopeful subthemes emerged: perceived ease of medication abortion and emphasis on primary care integration. Our results suggest that focusing on medication abortion and facilitating practice integration may bolster family medicine abortion provision. Toward a goal of increasing patient access, this hypothesis merits further study.

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