AVAILABILITY AND ATTITUDES OF RESIDENTS TO THE PROVISION OF ABORTION SERVICES

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ABSTRACT

Objectives: to determine the training and attitudes of obstetric and gynaecology residents to the provision of abortion services.
Design: a cross-sectional survey.

Setting: Canadian obstetrics and gynaecology residency programmes.

Interventions: a 15 item questionnaire exploring exposure to and training in abortion services, including the various techniques of pregnancy termination, counselling services, management of complications, and any negative effects experienced by those who chose not to perform these procedures during their training. Residents were also asked to indicate if they felt abortion training should be made a compulsory component of training programmes.

Results: one hundred and fifty-two out of a possible two hundred and sixty-six surveys were returned for a return rate of 57 percent. Sixty-six percent of residents who responded were willing to perform therapeutic abortions as part of their residency training programme and 52 percent planned to continue with this practice after graduating. Ninety-three percent of all responding residents felt competent to perform first trimester terminations and 62 percent felt competent to perform terminations using the intra-amniotic injection technique. Forty-two percent of residents felt competent to perform second trimester dilatation and evacuation procedures.

Of those who chose not to perform abortions, 34 percent did so for moral or religious reasons. Eighty-nine percent of residents felt that they were adequately trained to manage abortion complications and 86 percent received training in sexually transmitted diseases and contraceptive counselling. Thirty percent of residents felt that abortion training should be made compulsory and three percent of residents experienced adverse effects for refusing to perform abortions.

Conclusions: Canadian residency programmes offer residents a high level of exposure to the various aspects of abortion training, including the acquisition of technical skill, management of complications, and patient counselling. The majority of residents did not feel that abortion training should be made a compulsory component of their training programme.

Continued attention to this aspect of the specialty training curriculum is required to ensure that the continuing demands for abortion services can be met.

RÉSUMÉ

Objectifs : Déterminer la formation et les attitudes des résidents en obstétrique et gynécologie concernant les services d'avortement.

Conception : Enquête transversale.

Cadre : Programmes de résidence canadiens en obstétrique et gynécologie

Interventions : Un questionnaire en 15 points examinant l'exposition et la formation des résidents en matière de services

d'avortement, y compris les techniques d'interruption de grossesse, les conseils aux patientes et la prise en charge des complications, de même que les effets préjudiciables éventuels pour ceux qui décident de ne pas effectuer ces interventions durant leur formation. On a aussi demandé aux résidents d'indiquer s'ils estimaient que la formation à l'avortement devait faire obligatoirement partie du programme de formation.

Résultats : Sur 266 résidents, 152 ont répondu au questionnaire, soit 57 %. Environ 66 % des résidents ayant répondu étaient prêts à effectuer des avortements thérapeutiques dans le cadre de leur programme de formation en résidence et 52 % envisageaient de continuer cette pratique par la suite. Quelque 93 % de tous les répondants estimaient avoir la compétence nécessaire pour effectuer un avortement au premier trimestre, alors que 62 % s'estimaient aptes à effectuer un avortement par injection intra-amniotique et que 42 % des résidents s'estimaient capables d'effectuer une dilatation et une évacuation au deuxième trimestre.

Parmi ceux qui ont décidé de ne pas effectuer d'avortements, 34 % citaient des raisons morales ou religieuses. Environ 89 % des résidents estimaient qu'ils étaient convenablement formés pour prendre en charge les complications de l'avortement et 86 % recevaient une formation au counselling en matière de contraception et de maladies transmises sexuellement. Enfin, 30 % des résidents estimaient que la formation à l'avortement devait faire obligatoirement partie du programme de formation et 3 % ont signalé qu'un refus d'effectuer des avortements avait eu des effets préjudiciables pour eux.

Conclusions : les résidents des programmes de résidence canadiens sont largement exposés aux différents aspects de la formation à l'avortement, y compris l'acquisition des techniques, la prise en charge des complications et les conseils aux patientes. La majorité des résidents estimaient que la formation à l'avortement devait faire obligatoirement partie du programme de formation. Il convient d'accorder une attention soutenue à cet aspect du programme de formation de spécialité, de manière à pouvoir répondre à la demande éventuelle en matière de services d'avortement.

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KEY WORDS

Abortion, abortion services, resident training, cross-sectional survey.

INTRODUCTION

In 1991, 95,059 abortions were performed on Canadian women, resulting in a national abortion rate of 23.6 per 100 live births.[1] This rate shows a 2.3 percent increase in the number of abortions performed when compared to previous years. This has been partly attributed to an increased number of free standing abortion clinics. Of the total number of abortions performed in 1991, 70,277 (73.9%) were performed in Canadian hospitals. While the number of abortions performed in hospitals fell by 1.1 percent, those performed in private clinics, which accounted for nearly one-quarter of all abortions, rose by 15 percent. With an increasing number of private clinics offering abortion services, the demand for therapeutic abortions may rise even further.

Traditionally, this service has primarily been provided by Canada's obstetricians and gynaecologists. It is reasonable to assume that the majority of physicians who will provide abortion services in the future will come from residency training programmes in obstetrics and gynaecology. Little is known about the actual exposure that residents experience during their training period. Residency training programmes in Canada follow the educational objectives for training set out by the Council on Residency Education in Obstetrics and Gynecology (CREOG). These objectives state "that residents should have a knowledge of the indications, hazards and complications associated with first and second trimester terminations. Residents should also have knowledge of the various legal and ethical issues associated with abortion and should be able to give proper patient education and counselling. The resident should be able to carry out the required procedure or arrange contact with a facility and personnel that will be able to provide such a procedure."[2]

Because of changes in the numbers of post-graduates undergoing specialty training, in the attitudes of residents in training programmes, and in the pattern of delivery of abortion services, questions arise as to whether or not there will be enough well-trained physicians to meet the expected increase in demand. The objective of this study was to survey the opinions of residents in Canadian obstetrics and gynaecology training programmes about the various aspects of abortion training that they receive during their residency.

METHODS

In November 1993, copies of a two-page questionnaire were mailed to the Society of Obstetricians and Gynaecologists of Canada (SOGC) resident representative in each of the 16 Canadian obstetrics and

gynaecology residency programmes. A covering letter was attached to each of the surveys that introduced the study and its objectives and that requested the resident to complete the questionnaire anonymously and to return it to the investigators in a prepaid addressed envelope that was also provided. Sufficient copies were distributed to allow each resident enrolled in the programme to reply. The numbers in each programme were determined by a prior phone survey with the SOGC resident representative in each programme and were verified from the Canadian Postmedical Education Registry (CAPER). Questions were designed to enquire about the resident's exposure to abortion services in general, to the various techniques of pregnancy termination, to counselling services, and also the adverse effects experienced by those who chose not to perform these procedures during their training. Residents were also asked whether or not they felt that abortion training should be made a compulsory component of their training programme. There was only one mailing. A waiting period of six months was allowed for the return of all completed questionnaires before tabulating the results.

RESULTS

In all, 152 completed questionnaires, out of a 266 total possible, were received within the allotted time, for a return of 57 percent. The percentage of residents responding according to the geographical location of their programme was as follows: Quebec 73 percent; Western Canada (SK, MB, AB, BC) 57 percent; Ontario 42 percent; Atlantic Canada (NS, NF) 41 percent. Stratification of respondents according to their enrolment in the year of post-graduate training one through five was 19, 23, 23, 20, and 15 percent, respectively. Fifty-six males and 96 females responded. The age of participants ranged from 24 to 39 years.

Sixty-six of the residents surveyed stated that they were willing to perform therapeutic abortions (TAs), as part of their residency training programme and 60 percent have performed abortions at some time, either prior to or during residency training. Almost all residents (97%) had performed a dilatation and curettage procedure on patients with a non-viable pregnancy or for retained products of conception.

Fifty-two residents (34%) were unwilling to perform TAs. This was based on a variety of factors; seven (33%) refused for ethical reasons, nine (17%) refused on religious grounds, and 18 (35%) objected for a combination of moral and ethical reasons. One resident cited spousal objection as a reason for refusal.

When those residents who performed abortions were asked whether they would continue to perform abortions after graduation, 84 percent agreed that they would. Although no reasons were required, three residents, all from Ontario, stated that the threat of harassment from pro-life groups would dissuade them from providing abortion services. All residents were asked to assess what they thought their level of competency would be at the time of graduation in performing various abortion procedures. Ninety-three percent felt that they would be competent to perform first trimester dilatation and curettage procedures and a similar number felt that they would be competent to perform suction curettage. Sixty-two percent felt that they would be competent to perform second trimester terminations using intra-amniotic injections of either prostin, urea or saline, and only 42 percent felt that they would be competent to perform a dilatation and evacuation procedure.

Eighty-nine percent of residents, including those who refused to perform elective terminations, said that they received adequate training in diagnosing and managing the complications that may result from an abortion procedure. Residents who did not perform abortions did not object to managing those patients with complications. Eighty-six percent of residents said that their programme provided teaching in family planning and sexually transmitted disease (STD) counselling. Whether this teaching took the form of didactic lectures, or clinical rounds is not known. Sixty-nine percent of residents said that they counselled patients about alternatives to having an abortion.

In this study, only 30 percent of residents thought that abortion training should be a compulsory requirement of all residency programmes. Four residents (1 from Western Canada and 3 from Quebec) stated that disciplinary action in the form of negative assessments and poor working relationships with attending staff has resulted from their refusal to perform abortions. Five percent of residents felt that by performing abortions they could devote less time to performing other surgical procedures. Only 19 percent of residents felt that it would be appropriate to train paramedical staff to perform abortions in under-serviced communities.

DISCUSSION

The provision of abortion services has been called the "Clash of Absolutes." A clash between life and the freedom to choose. It is a subject that has divided society because it is fraught with myriad opposing social, moral, ethical, and religious viewpoints. Abortion training in residency programmes has the potential also to be a source of conflict.

Concerns have been raised about the thinning ranks of abortion providers[3,4] as well as the geographic maldistribution of access to abortion services.[5] A recent survey of its members was carried out by the SOGC in 1991, in preparation for a submission to the Canadian Senate deliberations over Bill C43 (an Act with respect to abortions).[7] This survey has provided some insight into the patterns of delivery of abortion services in Canada. Of the more than 760 respondents, 51 percent performed abortions. Of these, 52 percent performed only first trimester abortions, 31 percent performed both first and second trimester abortions, and only two percent performed second trimester terminations only. Twenty-nine percent of respondents admitted to having experienced harassment during the previous two years for performing abortions. Eight percent of respondents stopped doing abortions in the six months before the survey.

To help overcome the anticipated shortage in the provision of abortion services, several recommendations have been proposed to encourage resident training in these procedures. In the United States, a national symposium on the provision of abortion services was co-sponsored by the National Abortion Federation and the American College of Obstetricians and Gynecologists (ACOG) to try and explore possible remedies.[5] Suggestions included the integration of abortion training into residency programme training, and providing improved financial incentives and better working conditions for those providing abortion services. It has been proposed that abortion training should be made a compulsory component with exception made only for those residents who object on the basis of ethical or religious grounds.[8] Particular mention was made about the importance of training residents to perform second trimester terminations as they would be the only physicians trained to do these more complex procedures. Not all of these proposals have been met with favourable responses.[9,10]

All Canadian residency programmes surveyed offered abortion training to their residents. Except for some religiously affiliated institutions, this teaching takes place only in hospital-based teaching units. Two-thirds of residents surveyed have had exposure and training in performing abortions. Although residents were not asked to quantify their experience, nearly all residents, including those who did not do abortions, felt that at the end of the programme they would be adequately trained and competent to perform first trimester abortions. A possible explanation for this discrepancy could be that nearly all residents have performed evacuation procedures on non-viable pregnancies or for retained products of conception. This experience could lead them to feel competent to perform first trimester curettage procedures. Once again, nearly all residents, including those objecting to performing the procedure, felt competent in diagnosing and dealing with any of the complications that might arise following an abortion.

Only half of the residents surveyed said that they would be prepared to perform abortions after graduating. This corresponds to the number of physicians currently in practice who, in the SOGC survey, performed abortions. Sixty-two percent of residents felt competent to perform second trimester terminations using the intra-amniotic injection technique. Concerns about the lack of training and experience in performing second trimester dilatation and evacuation procedures appear to be well founded, as less than half the number of residents surveyed felt competent to do them.

Most residents objected to making abortion training a compulsory requirement of the residency programmes and, aside from a few situations, disciplinary action for choosing not to perform abortions does not seem to be prevalent. Residents also felt that by doing abortions, they did not limit their exposure to other areas of training.

Even the most ardent supporter of compulsory abortion training would not refuse to make exceptions for those residents who object for ethical or religious reasons. To date, however, no formal guidelines exist to define acceptable grounds for objection. A remedy to permit such exceptions and to limit cases of abuse has been suggested by Chervenak.[11] He suggests that residents document their objections in a similar fashion to "a citizen seeking conscientious objector status from serving in the military." In setting up such a system of guidelines, care must be taken not to infringe on personal or religious freedom.

Patient counselling in areas that include family planning or STD prevention seems to be adequately covered in the residency curriculum and training. However, in areas of unwanted pregnancy, counselling may need to be approached in a more non-judgemental fashion. Patients should be offered alternatives to having an abortion on a more consistent basis. Although some residents may find the situation uncomfortable because of their own personal ideals, all residents should approach this type of counselling in an objective and empathic manner, and should show respect for differing points of view.

From the results of this survey, it can be seen that Canadian residency programmes offer a high level of exposure and training to their residents in various aspects of abortion training. Although this study was not aimed at quantifying resident experience, there seems to be a higher percentage of resident participation in abortion training in Canadian programmes when compared to those in the United States.[12,13] Whether this is due to a lack of abortion legislation, a smaller number of residency programmes or a universal health care system, is difficult to say. Certain weaknesses in training have been identified, namely second trimester evacuation procedures, as well as aspects of patient counselling and decision making. A concerted effort should be made to encourage and improve training in these areas, in order for residents to feel confident in their ability to perform abortions at the end of their training.

Making abortion training a compulsory part of the residency curriculum would likely be unacceptable to both residents and staff who are opposed to performing abortions. As no guidelines currently exist as to what constitutes a "conscientious objector" status, the programme would run the risk of incurring legal action as well as damaging staff/resident relations. It would, therefore, be more advantageous for all parties if abortion training were maintained on a more "informal" basis and if a set of guidelines was substituted for a set of requirements.

By offering abortion training to as many consenting residents as possible, it is hoped that an ever increasing number of physicians starting out in practice would be trained and competent in performing abortions. This may help to stem the tide of attrition in the provision of these services. How many of these physicians will continue to practise and, just as importantly, where they will practise, remains to be seen. Residency programmes in those provinces with inadequate abortion services should have provisions in place to ensure that all interested residents are not only adequately trained, but are also encouraged and supported to provide these services in areas where they are most needed. Perhaps, by implementing some of the suggestions put forward by Grimes, a more equitable supply of services will exist.[3]

Private clinics are already responsible for performing just under one-quarter of all abortions in Canada. This percentage is expected to increase over time at the expense of hospital based procedures. Residency programmes should give thought to developing this resource into a suitable environment where residents could receive training in various abortion techniques.

In looking to the future, obstetrics and gynaecology residency programmes will likely remain the core from which the future providers of abortion services will be drawn. If a competent and a steady supply of abortion services are to be provided, it is imperative that sufficient teaching and support in all aspects of abortion training be made available to the residents.

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