Abortion Training in Obstetrics and Gynecology Residency Programs in the United States, 1991–1992

By H. Trent MacKay and Andrea Phillips MacKay

According to a 1991–1992 survey of program directors of obstetrics and gynecology residency programs in the United States, the overall percentage of programs providing any training in first-trimester (70%) or second-trimester abortion (66%) has changed very little since 1985. However, the proportion of programs providing routine training in first-trimester abortion decreased from 23% in 1985 to 12% in 1991–1992, and the proportion providing routine training in second-trimester abortion declined from 21% to 7%. The majority of the programs that dropped routine abortion training continued to offer optional training, but residents in programs with optional training were less likely to receive training. More than 80% of programs in private, non-Catholic hospitals and public hospitals provided some form of abortion training in 1991–1992, but only 6% of programs in Catholic hospitals and no military programs did so. In 45% of programs offering abortion training, residents performed one or fewer abortions per week.

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On February 14, 1995, the Accreditation Council for Graduate Medical Education (ACGME), which oversees medical education in the United States, announced a policy change requiring residents in obstetrics and gynecology to learn abortion procedures during their hospital training. Residents with moral or religious objections will be exempt, but accredited training programs must either provide training directly or rotate their residents through programs that do provide it. The ACGME policy change is a response to the current shortage of abortion providers, one of a number of recent developments that threaten access to abortion services in the United States. Trends in the training of obstetrics and gynecology residents in performing elective abortion procedures have been identified as important factors in the shortage of providers.[1]

Currently, approximately 1.5 million abortions are performed annually in the United States, with very low rates of morbidity and mortality.[2] Obstetricians and gynecologists have been the major force in the development and provision of these services, although physicians in other specialties have played an important role. Traditionally, residency programs in obstetrics and gynecology have been the only programs to formally train residents in abortion procedures and in the management of complications from spontaneous and elective abortions.

Nevertheless, shortly after the 1973 Supreme Court decision in *Roe* v. *Wade*, a survey of residency programs found that most university departments of obstetrics and gynecology were not providing routine abortion training in their programs.[3] A subsequent survey in 1976 revealed little change in the situation, with approximately 26% of programs providing routine training in first-trimester abortion and 23% providing training in second-trimester procedures.[4] However, at least 60% of the programs that were not providing routine training did offer abortion training as an option.

According to a 1985 survey, the proportion of programs providing routine training had remained stable since 1976, but the proportion of programs providing optional training had decreased.[5] A recent survey of obstetrics and gynecology residency program directors and chief residents found that nearly half of graduating chief residents had never performed a first-trimester abortion.[6]

This article reports on a survey in which we collected abortion training data from directors of obstetrics and gynecology training programs in the United States. Because our survey replicated those conducted in 1976 and 1985, we are able to document long-term trends in abortion training that have contributed to the current provider shortage.

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Methods

In September 1991, we mailed a two-page questionnaire similar to the one used in 1976 and 1985 to the 268 directors of residency programs listed by the Council on Resident Education in Obstetrics and Gynecology. The following month, we sent a second copy of the questionnaire to program directors who had not yet responded to the first mailing. Questionnaires were returned to us between September 1991 and April 1992.

We asked the program director or the individual responsible for abortion training to provide information on whether abortion training was currently included or had previously been included in the residency program, whether training was routine or optional, the reason for discontinuation of abortion services, the proportion of residents trained in first-trimester and second-trimester abortion procedures, the reasons for the decline in abortion training, the training location, the frequency of attending physician supervision of abortion procedures, the maximum gestational age at which procedures were performed, and the specific methods taught. We sought additional information about the number of procedures performed by residents, the permissibility of moonlighting to perform abortions, arrangements for abortion training in other institutions, the duration of the residency, the number of residents in the program, and the type of hospital. We also requested comments on abortion training. The directors were encouraged to respond anonymously if they felt uncomfortable about identifying themselves or their institution.

Findings

Of the 268 obstetrics and gynecology residency programs in the United States, 87% responded. This response rate is the same as the response rate for the 1985 study, and the respondents are representative of the geographic and institutional distribution of obstetrics and gynecology training programs in the United States. The highest response rates were from the Mountain, New England and West South Central census divisions, and the lowest response rate

was from the East South Central division.* We received responses from 98 of 109 programs in public hospitals; 93 of 115 programs in private, non-Catholic hospitals; all 31 programs in Catholic hospitals; and 11 of 13 programs in military hospitals.

Seventy percent of responding programs reported that they offer training in first-trimester abortion, including 12% that provide routine training and 58% that provide optional training (Table 1). Among responding residency programs, 84% of those affiliated with public hospitals and 86% of those affiliated with private, non-Catholic hospitals said they provide such training. Only two programs in Catholic hospitals (6%) and none of the military programs provide first-trimester training. Programs based in private, non-Catholic hospitals are more likely to provide routine first-trimester training than are those in public hospitals (17% vs. 12%). The one program in a Catholic hospital that provides routine training is also affiliated with a private, non-Catholic hospital. The other Catholic hospital program with first-trimester training offers it as an option.

Overall, 65% of responding programs reported providing training in second-trimester abortion. About 6% of programs in public hospitals and 11% of those in private, non-Catholic hospitals offer it routinely, but none of the programs in Catholic-affiliated hospitals or military hospitals do so, and only one of 31 programs based in Catholic-affiliated hospitals provides optional training.

The proportion of training programs providing routine training in first-trimester abortion dropped from 26% of programs in 1976 and 23% in 1985 to 12% in 1991–1992. The change in routine second-trimester abortion training was even more marked, with 7% of programs providing routine training in 1991–1992, compared with 23% in 1976 and 21% in 1985. There was little overall change between 1985 and 1991–1992 in the number of programs providing training because the decrease in programs providing routine training was counterbalanced by an increase in the number providing optional training.

Because the size of residency programs varies, we also analyzed the most recent data by the actual number of residents in each responding program. The percentage distribution of residents, by affiliation and availability of training, is similar to the distribution of programs by availability of training (Table 2, page 114).

Whether abortion training is considered a routine, integral part of the program or an option is an important determinant of resident participation. Thirteen percent of programs providing first-trimester training (22 of 164) indicated that all residents participate, and 9% of those providing second-trimester training (14 of 153) reported that all residents do so (Table 3, page 114).

Among programs with routine first-trimester training , all 29 reported that more than one-half of their residents participate, and 97% (28) reported that more than three-quarters do so. In contrast, 53% of programs (72 of 135) with optional first-trimester training reported that more than half of their residents receive training, and only 29% of programs (39) said that more than three-quarters of residents do so. The distribution of programs in public hospitals by availability of first-trimester training is similar to the distribution of private, non-Catholic facilities.

Table 1. Percentage distribution of U.S. obstetrics and gynecology residency programs, by type of abortion training and hospital affiliation, according to trimester and year

Type of training and affiliation	First trimester			Second trimester		
	1991–1992	1985	1976	1991–1992	1985	1976
Routine	**12.4***	**22.6**	**26.3**	**6.9****	**20.6**	**22.5**
Public	12.2	28.3	18.8	6.1	26.1	16.2
Private						
Non-Catholic	17.2	27.2	36.3	10.8	25.2	31.0
Catholic	3.2	4.9	0.0	0.0	2.4	0.0
Military	0.0	0.0	u	0.0	0.0	u
Optional	**57.9**	**49.6**	**66.2**	**58.4**	**44.0**	**61.5**
Public	71.4	58.7	76.2	72.4	52.5	72.5
Private						
Non-Catholic	68.9	56.3	63.7	70.0	48.5	58.4
Catholic	3.2	21.9	40.0	3.2	22.0	35.0
Military	0.0	16.7	u	0.0	16.7	u
None	**29.6**	**27.8**	**7.5**	**34.8**	**35.5**	**16.0**
Public	16.4	13.0	5.0	21.4	21.7	11.3
Private						
Non-Catholic	13.9	16.5	0.0	19.4	26.2	10.6
Catholic	93.5	73.2	60.0	96.8	75.6	65.0
Military	100.0	83.3	u	100.0	83.3	u
Total	100.0	100.0	100.0	100.0	100.0	100.0

N=98, public; 93, private non-Catholic; 31, private Catholic; and 11, military. *Significantly different from 1985 at p<.002. **Significantly different from 1985 at p<.0002. *Note:* u=unavailable. *Sources:* **1976:** see reference 4; **1985:** see reference 5.

Only 16 programs provide routine second-trimester training, but all reported that more than three-quarters of their residents participate. Of the 137 programs with optional second-trimester training, only 40% (55) reported that more than half of their residents participate. The distribution of programs in public hospitals by availability of second-trimester training is similar to that in private, non-Catholic hospitals.

In programs providing abortion training, religious or moral objections were the most common reason given for why residents choose not to participate. Forty-three percent of programs providing first-trimester training reported that more than 90% of residents who refuse to participate do so for religious or moral reasons. The pattern for refusal to participate in second-trimester training is similar.

Among programs providing first-trimester abortion training, 71% provide training in the hospital (not shown) and 57% provide training in either a clinic setting or an outpatient surgical unit, with some programs providing training in both locations. Second-trimester training is more likely to occur in a hospital (76%) than in a clinic or outpatient surgical unit (33%). Twenty percent of programs with abortion training reported that training is conducted either in a clinic not affiliated with the primary teaching hospital or in another hospital.

All of the programs reported that an attending physician is sometimes present when a resident performs a surgical abortion, and two-thirds of the programs said an attending physician is always present (not shown). Sixty-six percent of the programs said an attending physician is always present during first-trimester abortions, and 23% reported that a physician is present during most procedures. For second-trimester abortions, those figures are 88% and 10%, respectively.

Among programs that include second-trimester abortion training, 96% provide training in procedures using prostaglandin preparations, 84% in dilatation and evacuation (D&E) and 26% in saline abortion (not shown). Overall, 84% of these programs provide training in abortion procedures at gestations of more than 16 weeks and 43% provide training at gestations of more than 20 weeks. However, although D&E has become the most common method of second-trimester abortion used in the United States, only 43% of these programs provide training in D&E at gestations of more than 16 weeks and only 9% provide such training at gestations of more than 20 weeks.

*Mountain: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah and Wyoming; New England: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont; West South Central: Arkansas, Louisiana, Oklahoma and Texas; East South Central: Alabama, Kentucky, Mississippi and Tennessee.

Table 2. Percentage distribution of obstetrics and gynecology residents, by type of training and hospital affiliation, according to trimester, 1991–1992

Type and affiliation	First trimester	Second trimester
Routine		
Public	13.5	5.8
Private		
non-Catholic	22.1	12.5
Catholic	2.5	0.0
Military	0.0	0.0
Optional		
Public	71.0	74.9
Private		
non-Catholic	70.1	73.4
Catholic	3.8	3.8
Military	0.0	0.0
None		
Public	15.7	19.2
Private		
non-Catholic	7.8	14.1
Catholic	93.7	96.2
Military	100.0	100.0

Forty-five percent of programs with training indicated that residents perform no more than one first-trimester abortion procedure a week as part of the program. Among programs with routine training, 21% reported that residents perform no more than one first-trimester abortion a week, while 48% reported a total of more than five a week. In contrast, among programs with optional training, 50% said residents perform one or fewer abortions a week, while 14% reported a total of more than five a week (Figure 1).

In 72% of all programs with training in second-trimester abortion, residents perform no more than one such procedure per week (not shown). Of programs with routine second-trimester training, 31% reported that residents perform no more than one abortion a week, while 25% reported more than five a week. In contrast, among programs with optional training in second-trimester abortion, 77% reported that residents perform one or fewer such procedures a week, and only 3% reported a total of more than five a week.

Moonlighting at other facilities is a potential source of experience for residents in performing abortion procedures. Thirty-four percent of programs with abortion training allow moonlighting, while 29% of programs without abortion training do so. Programs in private hospitals are slightly more likely than those in public hospitals to allow moonlighting (35% vs. 31%). Thirty-nine percent of programs in Catholic hospitals allow moonlighting, while none of the military programs do so. Respondents did not indicate the number of residents moonlighting at other facilities.

We solicited information regarding the effects of the changing legal, legislative and social environment on abortion training. Fifteen programs indicated that they had previously provided abortion training but no longer do so. Of these, seven programs had ceased training as the result of legislative or legal directives: Five are in military hospitals, where abortions were prohibited by executive order at the time of the survey,* and two are in public hospitals in Missouri, where public institutions are no longer able to provide abortion training because of the 1989 Supreme Court decision in *Webster* v. *Reproductive Health Services.*

The remaining programs were the victims of the political and social environment. One program based in a private hospital discontinued training because residents were not interested in learning abortion procedures. Community pressure was cited by four respondents. Specific circumstances cited included the decision of a county board of supervisors, restrictions on county funds for hospital support, and community tension related to abortion. One respondent cited the decision of the hospital director to suspend abortion training. Another program, based in a private hospital, dropped abortion services as a condition of affiliation with a Catholic hospital.

Respondents' Comments

Of the 233 program directors responding, 56% added narrative comments. Although these responses do not necessarily represent the views of all program directors, they provide some additional insights. Twenty-four respondents emphasized the importance of abortion training for all residents in obstetrics and gynecology training programs. One respondent commented, "It should be a requirement for all programs to provide residents with the training experience, if not at the training institution, then at another. The resident should have the freedom to decline the training on religious or moral grounds without prejudice." Four respondents, all from programs not providing training, indicated complete opposition to abortion training. "It should not be part of residency training... To imply that all residents should be trained in abortion when so many are opposed...is repugnant," commented one director.

Twenty-one respondents indicated that community pressure, governmental restrictions or hospital policy limited their ability to provide abortion training. One program director commented, "Abortion is taking severe political pressure in this community including both demonstrations and threats against families of those performing abortions. Hospitals are very sensitive to pressures."

Absence of funding for abortion for indigent women was cited as a limiting factor in four programs. Eight program directors commented that there was low

Table 3. Number of responding obstetrics and gynecology residency programs that offer abortion training, by estimated percentage of residents participating, according to trimester, type of training and hospital affiliation

Trimester, type and affiliation	N	% of residents participating					
		0	1–25	26–50	51–75	76–99	100
FIRST TRIMESTER							
Routine	**29**	**0**	**0**	**0**	**1**	**12**	**16**
Public	12	0	0	0	1	3	8
Private							
non-Catholic	16	0	0	0	0	9	7
Catholic	1	0	0	0	0	0	1
Optional	**135**	**2**	**24**	**37**	**33**	**33**	**6**
Public	70	1	15	17	18	16	3
Private							
non-Catholic	64	1	9	19	15	17	3
Catholic	1	0	0	1	0	0	0
SECOND TRIMESTER							
Routine	**16**	**0**	**0**	**0**	**0**	**7**	**9**
Public	6	0	0	0	0	2	4
Private							
non-Catholic	10	0	0	0	0	5	5
Catholic	0	0	0	0	0	0	0
Optional	**137**	**5**	**34**	**43**	**23**	**27**	**5**
Public	71	3	20	20	11	14	3
Private							
non-Catholic	65	2	13	23	12	13	2
Catholic	1	0	1	0	0	0	0

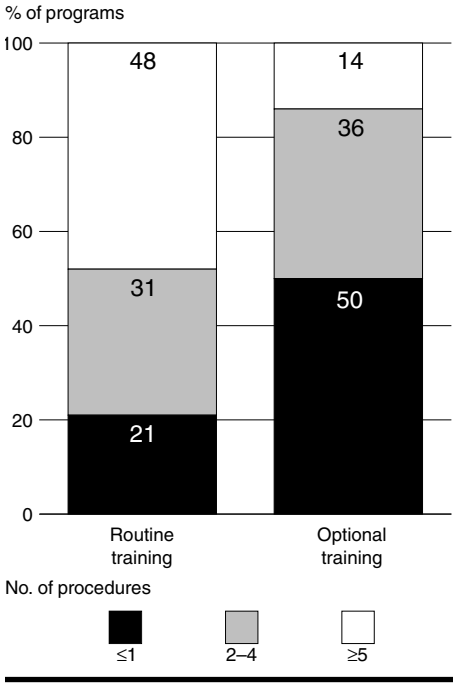
*Although President Clinton has since revoked the executive order (issued by former President Reagan) proscribing abortion in military hospitals, a legislative ban on the use of federal funds for abortion remains in place. The health insurance plan for federal employees, which is paid for with government funds, is specifically prohibited from covering abortion.

demand for abortion procedures at their training institutions because freestanding abortion clinics in the community were able to provide services more efficiently and at lower cost. However, six program directors said that they had made arrangements for their residents to receive optional training at freestanding clinics in the community.

Seven respondents indicated that a lack of resident interest in abortion training had led to discontinuation or limitation of abortion training. "It is my observation that when residents are given the option…, sooner or later the majority…develop reasons for not performing these procedures," commented one respondent.

Twenty respondents indicated that although their institution did not provide elective abortions, their residents received adequate experience by managing cases of incomplete or missed abortions, abortion complications or terminations for fetal demise. One program director commented, "Whereas performing abortions is not permitted in this institution, the use of the suction machine in incomplete spontaneous abortion and the use of laminaria and prostaglandins in mid-trimester fetal demise afford the residents an opportunity to develop technical skills." However, another respondent wrote, "Using spontaneous abortion as a model is inadequate."

Figure 1. Percentage distribution of obstetrics and gynecology training programs, by number of first-trimester abortions that residents perform each week, according to availability of training



Discussion

Because abortion continues to be the most frequently performed surgical procedure in the United States, the availability of trained providers remains an important issue. The training of obstetrics and gynecology residents in abortion procedures is an important factor in maintaining the continued availability of providers.

We have identified a number of barriers to the receipt of abortion training. Although more than two-thirds of the programs provide training, it is not a routine part of the curriculum in the majority of programs. Consequently, the proportion of residents being trained in abortion has decreased, because residents in programs with routine training are much more likely to participate in training than are those in programs with optional training. Residents are usually fully occupied with clinical activities, and optional training in any area often requires either spending additional time or displacing other, competing activities. In addition, some residents are concerned about being stigmatized for performing abortions and feel that they are unlikely to perform abortions once in practice.

The new ACGME requirements will assure that residents in all programs have access to abortion training, but many barriers to the routinization of training remain. In most communities, the lower prices charged by freestanding clinics have decreased the proportion of abortions performed in hospital settings, leaving residents with limited opportunities to develop their skills. In 1973, more than 50% of abortions were performed in hospitals, compared with only 10% in 1988.[7]

During the past two decades, the antiabortion movement has become increasingly vociferous and violent, and harassment of abortion providers has become a common occurrence.[8] The threat of violence affects the willingness of residents to participate in abortion procedures, as well as the willingness of program directors or hospital administrators to continue on-site abortion training and services.[9] Although antiabortion violence is usually directed against freestanding clinics rather than hospitals that provide training, the prevailing religious and political attitudes toward abortion may convince some residents to avoid performing abortion procedures in their training program as well as in practice. And although 1.5 million abortions are performed annually in the United States, abortion is not uniformly seen as an important part of the skills that obstetricians and gynecologists should possess if they are to provide a full range of reproductive health services.

Another issue is the "graying" of abortion providers.[10] Many of the physicians who teach abortion in training programs or perform abortions in clinics are now nearing retirement.

The problems outlined here can be solved. Darney and colleagues have suggested that alliances between training programs and freestanding clinics would benefit both parties.[11] The program participants would supply a continuing source of providers and the clinics would provide an adequate number of patients and training under the supervision of experts. Programs that lack faculty with an interest in abortion may need support in the form of speakers and teaching materials.

Because health care reform may result in a decrease in the number of residency programs in obstetrics and gynecology, it may be useful to provide formal abortion training to residents in family practice and general internal medicine programs. Another alternative is the training of midlevel practitioners. Whatever the future may hold, there will be a continuing need for well-trained obstetricians and gynecologists, both to provide abortion services and to provide backup for the treatment of the occasional serious complication.

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