LETTERS

How Available Is Abortion Training?

We appreciate the recent publication in *Family Planning Perspectives* of an analysis suggesting that routine training in abortion care has increased [Abortion training in U.S. obstetrics and gynecology residency programs, 1998, 2000, 32(6):268–271 & 320]. We would like to believe that this is the case, but the study's methodological shortcomings raise serious questions about whether the conclusions drawn by the authors are valid and in fact point to an improvement in resident training.

The authors clearly acknowledge two major handicaps of the study: a low response rate and a lack of definition of routine versus elective training. The low response rate implies a response bias, and in fact the authors prove a response bias by comparing those who responded early with those who replied late [p. 270]. In addition, by not asking detailed information about abortion methods, they may have missed important clues about resident experience. Moreover, they restricted the survey to program directors; two previous surveys included both program directors and chief residents.[1]

The failure to spell out what routine training entails puts the findings most seriously into question. The authors do not describe how they defined routine and optional training. It has been shown in other studies that these definitions are often misunderstood. A previous study of family planning training in family practice programs found that many respondents' comments indicated a misunderstanding of the basic terms routine and optional.[2]

Some of the authors' findings lead us to question whether their respondents understood the difference between routine and optional training. For example, 46% of the programs offering training described doing so routinely for first-trimester abortions (up from 12% in a previous survey), and 44% of the programs reported providing routine second-trimester training (an even more impressive change from a level of 7% reported in 1992).[3] Yet the participation level of residents in training described as routine in 2000 was considerably lower than that in the previous survey: Eighty-three percent reported that half or more of their residents received such routine training, while in 1992, 97% (virtually all programs that claimed routine training) reported that more than *three-quarters* of their residents did so. The question we must ask is whether a definition of routine training can allow such a low level of participation.

The authors indicate that in the questionnaire's Comments section, 18 program directors said that "elective abortions" are not performed in their program, but the authors do not state how these 18 labeled the training their programs offered. Comments by one program director described as "typical" by the authors further confirm our suspicions. Although the director describes the abortion training program as routine, he also states that abortion training is considered optional within the department and that a resident has the choice of opting out of the rotation.

When Medical Students for Choice conducted a similar survey prior to that conducted by the National Abortion Federation (NAF), they attempted to avoid this confusion by referring to the training as required. This, in turn, led to confusion among those programs that have a routine rotation but allow their residents to opt out. As a result, the program here at the University of California San Francisco, which has a six-week rotation dedicated to abortion training, was not listed in the Medical Students for Choice guide as having a routine or required rotation. The questions, then, are how to define routine training and what advantages such training programs have over "optional" or "elective" training.

The Kenneth J. Ryan Residency Training Program in Abortion and Family Planning (a national program dedicated to enhancing residents' training in these areas) defines training as routine when there is either a separate rotation or allocation of dedicated time as part of another rotation, when the resident is systematically taught a variety of techniques in settings not restricted to the operating room and when the number of procedures is adequate for the trainee to gain proficiency. As the authors mentioned, most hospitals perform very few abortions. To address this shortcoming, our program, besides setting up rotations through freestanding providers, also encourages hospitals to "reintegrate abortion within the mainstream of outpatient surgery...."[4]

A third serious shortcoming was that the NAF study did not ask program directors to describe the methods of abortion in which the residents were trained. One comment from a program with optional training was particularly telling: "Please note training is voluntary and limited to patients with medical indications." Abortions limited to patients with medical indications are often medical inductions of labor performed on the labor and delivery wards, and are different from most elective abortions.

Residents whose training is limited to medically necessary abortions often do not have exposure to pregnancy options counseling, placement of a paracervical block, cervical dilation, and the technical difficulties of dilation and evacuation. (Dilation and evacuation, which is safer than induction of labor, is the most frequently performed method of second-trimester abortion.) In addition, a number of abortions are for genetic abnormalities. Again, these are mostly performed in an operating room or labor and delivery setting, and do not give residents the experience with adequate numbers of proce-

dures and the skills that they would need if they were to include abortion in their future practices.

A future survey might inquire into the types and numbers of procedures, as well as into the clinical settings in which they occur. Moreover, other important questions should be addressed: Has the gestational age limit changed in the past 10 years? Has training in dilation and evacuation increased to reflect its status as the method of choice for second-trimester abortion? Has manual vacuum aspiration—a method that has become increasing popular, since it can be performed very early in pregnancy, under local anesthesia and in a private-practice setting—been incorporated into the variety of methods taught to residents?

The authors do not explicitly acknowledge one additional bias: The response may have been influenced by the fact that the survey had been sent by a national organization of abortion providers that is a leading advocate for residency training to increase the number of physicians able and willing to perform abortions. Did the respondents who answered the survey give the answers that they thought NAF expected to hear?

Finally, we question whether the results can or should be compared with those of previous surveys on abortion training, since the current survey did not attempt to replicate surveys conducted in 1976, 1985 and 1991–1992. We lack meaningful information about numbers, methods, and when and why the training programs were changed in a particular program.

All standard-setting bodies in obstetrics and gynecology (i.e., the American College of Obstetricians and Gynecologists, the Council on Resident Education in Obstetrics and Gynecology, the Association of Professors of Gynecology and Obstetrics and the Accreditation Council for Graduate Medical Education) issued explicit statements in 1996 that exposure to abortion training is an essential component of resident training. Thus, as the authors suggest, what we can conclude from the study's results is that department program directors may be more likely to indicate that their residents receive abortion training.

The authors set out to assess whether these requirements have had an effect on residency training programs. Media coverage of the study suggested that there has been a dramatic change in the past 10 years. Working with residency programs throughout the United States, we wonder whether such positive news is warranted and whether it will only reinforce the professional complacency that hampers the establishment of adequate resident training in abortion.

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2. MacKay HT and MacKay AP, Abortion training in obstetrics and gynecology residency programs, *Family Planning Perspectives,* 1995,27(3):112–115.

3. Ibid.

4. Chavkin W and Rosenfield A, Abortion training: a necessary part of the return to excellence, letter to the editor, *American Journal of Obstetrics and Gynecology,* 1995, 172(3):1070.

The authors respond:

We thank the writers for their comments. Given that this was the first published survey examining the availability of abortion training in obstetrics and gynecology residency programs since the ACGME instituted new standards for abortion training, and given that the last published studies on this topic were conducted in the early 1990s, we anticipated that the article would generate interest and discussion.

The majority of the issues addressed in this letter are, in fact, points that we have already identified as problems and examined at length in the original article. Although the letter leaves the impression that we underestimated or overlooked these limitations, nearly 20% of our paper is devoted to a discussion of these very points, including low response rate, the strong likelihood of a response bias, confusion among respondents about the operational definitions of "elective" and "routine" abortion training, possible misrepresentation of the degree of abortion training because the National Abortion Federation conducted the survey, and differences in program directors' versus residents' assessments of the extent of training. Because of these limitations, we explicitly warned against generalizing our findings to the survey universe.

As is the case with all survey research, we had to make decisions about how to construct our survey to optimize response rates. Uta Landy and Jody Steinauer have offered valid suggestions for alternative ways in which future surveys might be constructed to explore different details related to the abortion training occurring in obstetrics and gynecology residency programs. We encourage them or others to conduct such research, and we look forward to the results.

We also agree that due to space limitations and other factors, media coverage of scientific studies is often simplistic. This was the case in the coverage of our findings. As we stated in the article, we are "cautiously optimistic" that the availability of routine abortion training in obstetrics and gynecology residency programs has increased. But far from inviting complacency or suggesting that the abortion training problem has been solved, our conclusions point to three overriding needs: to incorporate both first-trimester and second-trimester abortion training into more residency programs; to ensure that residents are fully trained in appropriate settings; and to set higher expectations for resident participation.