center which performs elective abortions.”

Ten respondents labeled their institutions in a particular way (e.g., military, Catholic and “conservative community”) to explain the reasoning behind their policies regarding abortion training. Eight programs indicated that even though they provide the opportunity to train, most residents do not participate.

Six respondents pointed out that very few abortions occur in hospitals because of the expense, and that this low volume makes it difficult to train residents adequately. Three directors specifically requested that we keep their programs’ activities confidential, and two commented that they are supportive of abortion training. One respondent wrote about the “need to work on resident awareness about what happened to women before abortion was legal.”

Discussion

Our results document a shift toward routine abortion training. A 1991–1992 study found that 70% of residency programs offered abortion training, and 12% provided it routinely. In our study, 81% of programs reported offering first-trimester training, and 46% reported doing so routinely. Similarly, in 1991–1992, 66% of residency programs reported offering second-trimester training, while our study shows an increase to 74%. The rise in routine second-trimester training is particularly dramatic: from 7% in 1991–1992 to 44% in our survey. Our finding that programs reporting optional abortion training have lower levels of resident participation than programs that offer training routinely supports the results of previous research.

**Study Limitations**

Taking our results at face value, it would be simple to conclude that routine abortion training opportunities have skyrocketed. However, there is reason to be cautious in interpreting the results because of several potentially important factors: response bias, variability in respondents’ interpretations of survey questions and reporting bias.

The 1991–1992 study had a response rate of 87%, by comparison, ours had a response rate of 69%. A response bias very probably exists among this smaller pool of respondents. Furthermore, although respondents are demographically similar to the survey universe, the analysis of early and late responders uncovers the need for caution in generalizing the findings to all residency programs. The programs that responded to our first request for information reported greater availability of routine first-trimester training and higher resident participation rates than programs that were contacted several times before they returned completed surveys. Assuming that nonrespondents are similar to late responders, the pool of respondents may represent a self-selected sample, with a bias toward reporting routine training.

Because of the likelihood of response bias, it is difficult to make assumptions about nonrespondents and we have not attempted to generalize our findings to the survey universe. The usual statistical assumption that the same proportion of nonrespondents as of responding programs offer routine training (46%) would most likely be an overestimate, given the difference in availability of training between early and late responders. However, if we assume that all nonrespondents (i.e., 31% of the survey universe) do not offer routine training, we would most likely underestimate the actual availability of routine abortion training in obstetrics and gynecology residency programs. In either case, however, routine training is offered by a higher proportion of respondents to our survey than to earlier surveys (Table 6). To further illuminate our results, it is noteworthy that an official on the ACGME’s Residency Review Committee for Obstetrics and Gynecology estimated that in 1997, 35% of residents completing their fourth year of training in obstetrics and gynecology had not performed a single abortion.

Program directors were asked to specify whether first- and second-trimester abortion training was routine or elective in their residency programs, but the survey did not specifically define these two terms. Thus, respondents may have crafted their own definitions of “abortion training,” “routine” and “elective,” on the basis of their political and academic situations and understandings. Pressure to affirm the presence of abortion training in residency programs may come from the new ACGME standard, which links abortion training with accreditation. No residency program could lose its accreditation simply because it does not offer abortion training; however, program directors may have exaggerated the existence and routine nature of abortion training, especially if they are under the misapprehension that NAF is a political watchdog organization.

It is also possible that program directors’ perspectives on the availability of abortion training may not match the perspectives of residents. Our study did not assess residents’ perceptions of either the availability of abortion training or faculty’s expectations about their participation in it. However, an earlier survey that gathered data from both program directors and residents found that residents consistently reported less clinical experience than did their program directors. A similarly designed study revealed that program directors also reported more “verbal instruction” than did the chief resident. Thus, even in the absence of reporting bias on the part of residency program directors, abortion training may not be as available as our data suggest if discrepancies exist between program directors’ and residents’ perceptions.

(continued on page 320)