

**Objectives:** Pre-procedure ultrasound imaging is a routine part of abortion care. Little is known about which patient characteristics are associated with choosing to view the ultrasound, or if the choice to view is associated with any subsequent decision to proceed to termination.

**Methods:** Data from 15,575 patient visits to a large, urban abortion provider in Southern California in 2011 were analyzed for patient demographics, the patients' decision certainty, the choice to view or not view the ultrasound image, and whether those patients who choose to view their ultrasound images were more or less likely to proceed to termination.

**Results:** Some 42.5% of patients chose to view their images. Choosing to view was associated with being non-white, young (under 25), of lower socioeconomic status and less sure of the decision to terminate. Choosing not to view was associated with being older than 30, being multiparous or having a greater gestational age (more than 9 weeks). Among those who chose to view, 98.4% proceeded to termination. Of those who chose not to view, 99.0% proceeded to termination. Viewing was significantly associated with deciding to continue the pregnancy only among the 7.4% of women who reported medium or low decision certainty on presentation for care.

**Conclusions:** Some patients are interested in viewing their ultrasound images when offered the opportunity to do so in a non-coercive setting. Viewing may contribute to a small number of women with medium or low decision certainty deciding to continue the pregnancy.

## P7

### RESIDENT AWARENESS AND EXPERIENCE WITH ABORTION AND FAMILY PLANNING-RELATED RESTRICTIONS

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**Objectives:** To assess awareness and experience of ob-gyn residents regarding abortion-related policies and restrictions.

**Methods:** The Kenneth J. Ryan Residency Training Program provides 2 years of support to ob-gyn departments to integrate abortion and contraception training into residency education. Residents complete Web-based pre- and post-rotation surveys, which assess their clinical skills in abortion and family planning.

**Results:** Since September of 2012, 70 residents have completed a pre-rotation survey, for a response rate of 69%, and 42 residents have completed a post-rotation survey (53%). Although most residents were aware of local or state policies restricting abortion, that proportion increased from 88% before the rotation to 97% after completing the rotation. Nearly 20% received information or training related to family planning policy, legislation or advocacy during their rotation. The majority of residents (67%) who did not receive this information expressed a desire to include it in their training. More than half of residents (62%) reported an experience on the rotation in which restrictions negatively affected a patient seeking services. This proportion varied by region: 50% in the Western United States, 69% in the South, 71% in the Midwest and 67% in the Northeast. The most commonly reported restrictions were gestational age limits (36%) and mandated waiting periods (26%).

**Conclusions:** On the Ryan Program rotation, most residents reported increased awareness of restrictive legislation and desired additional information or training in policy and advocacy.

## P8

### PROSPECTIVE COHORT OF U.S. OB-GYNS REGARDING ABORTION TRAINING AND PRACTICE POST-RESIDENCY

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**Objectives:** To determine the impact of routine family planning and abortion training during residency on abortion practice 2 years after residency.

**Methods:** In 2012, we surveyed graduated ob-gyns 2 years after completing residency training about their current abortion practice. All respondents consented to join a prospective cohort, either as part of the routine evaluation of the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning or during a cross-sectional study of all U.S. ob-gyn residents completing training in 2010.

**Results:** Of the 314 physicians who consented to be contacted, 175 completed the survey, for a response rate of 56%. All respondents reported the availability of some abortion training in residency; 128 (73%) reported routine abortion training, and 47 (27%) reported non-routine training. Forty percent of respondents performed abortions in the last year. A higher proportion of physicians with routine residency training performed abortions (45% vs. 28%,  $p=.03$ ), and among those who had done so, those with routine training did more abortions on average (66% vs. 41%,  $p=.06$ ) in the last year.

**Conclusions:** Two years after residency, 40% of physicians in this sample reported doing abortions in the last year. Physicians who experienced routinely integrated abortion training in residency were more likely to include abortion in their practice.

## P9

### PERSPECTIVES ON SEXUALITY INSTRUCTION AMONG MEDICAL RESIDENTS

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**Objectives:** This study assessed the quantity and effectiveness of sexuality instruction received by medical residents, as well as their self-perceived knowledge, comfort and communications regarding patient sexuality issues.

**Methods:** A cross-sectional survey was constructed to evaluate medical residents in various clinical residency programs of an urban medical school. Residents were asked about knowledge, comfort, communication and perceived barriers to discussing patient sexual health issues.

**Results:** Of 366 eligible residents, 122 residents in 11 programs participated (33.3% response rate). Seventy percent reported receiving no sexuality instruction during their residency so far, and 85% reported receiving 0–3 h of sexuality instruction. Only 46.6% felt they would be prepared to address patients' sexual health after completion of their program. Of 30 sexuality topics listed, only three had more than 50% residents reporting "very strong" or "adequate" instruction received: HIV, STIs and anatomy/physiology. Several topics had more than 80% reporting "minimal education" or "no education," including transgender patients; intersex patients; legal issues in sexuality; sexual response cycle; sexual pleasure; lesbian, gay and bisexual patients; and chronic illness and sexuality. More than 70% responded that education on these topics would be clinically useful: abortion, anatomy/physiology, child sexual abuse, HIV, sexual assault/trauma, sexual history taking, sexual side effects of medications and STIs. Sixty-one percent reported never or rarely initiating sexual health discussions with patients.

**Conclusions:** Integrating sexual health education into the curricula of medical residency programs would benefit physicians and their patients. Physician knowledge and comfort in discussing patient sexuality is a critical component of family planning health care.

## P10

### BARRIERS AND FACILITATORS TO THE INVOLVEMENT OF NURSES IN ABORTION CARE PROVISION

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**Objectives:** To describe the barriers and facilitators to the involvement of nurses in abortion care provision.

**Methods:** Qualitative semi-structured interviews were used to collect data from nurses and grounded theory methods were used to analyze the data.

**Results:** Several factors influence nurses' decision-making regarding care for women seeking abortions. Facilitators of participation include the reasons for the abortion, the level of empathy for the patients and personal commitment to women's autonomy. Barriers to participation include poor communication with co-workers and other professions; institutional issues, such as confusion regarding documentation and fetal remains disposition; having an unclear role in the care of these women; and uncertainty in their ability to meet basic care needs of patients and their families, particularly emotional and social support in the context of end-of-life care for the terminated fetus. All units have informally designated staff to specifically care for women seeking abortions. In other words, a small number of nurses routinely elect to care for these women.

**Conclusions:** Nurses have complex opinions regarding the provision of nursing care to women seeking abortions. Several domains affect nurses' ability to participate in abortion care, which include personal, patient, institutional and familial characteristics that can facilitate or be barriers to nurses' level of comfort participating in abortion care.

## P11

### PREGNANCY TERMINATION PRACTICE PATTERNS AMONG MATERNAL FETAL MEDICINE SPECIALISTS

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**Objectives:** This survey sought to gain a better understanding of the pregnancy termination practice patterns of maternal fetal medicine (MFM) physicians.

**Methods:** Members of the Society of Maternal Fetal Medicine were surveyed electronically regarding training experience in pregnancy termination, counseling, and referral patterns for services.

**Results:** Some 1467 members were identified, and 280 responses, yielding a response rate of 20.1%. The majority of respondents held an academic appointment (faculty and fellows; 49.5%); 61.4% have been practicing for more than 10 years. The majority of respondents offered counseling for pregnancy termination (98.9%). Both medical and surgical termination options were discussed by 96.7% of respondents; 41.7% actually provided surgical procedures themselves, with 25.2% performing dilation and evacuations (D&Es). Of respondents performing dilation and curettage or D&E, most received training during residency (83.8%) versus in fellowship (12.2%).

**Conclusions:** MFMs often care for women facing the difficult decision of pregnancy termination. It is reassuring that the majority of MFMs surveyed provide counseling about pregnancy termination options, and many are trained providers. The findings suggest that the provision of surgical pregnancy termination services may be limited by residency education. Residency programs that provide training for pregnancy termination are important in improving patient access to these important services.

## P12

### THE "CARING PARADOX"? ABORTION CARE AND NURSING STAFF

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**Objectives:** Nurses identify with the label "pro-life" more than members of other health care professions, and researchers hypothesize that this is related

to nursing as a "caring science." Here we consider whether nurses experience participation in abortion as a conflict with the "caring" mission of the nursing profession.

**Methods:** We conducted a multi-site study of the Providers Share Workshop in 2010–2012. Providers Share is a five-session facilitated group workshop in which abortion providers meet to discuss their work. Sessions were recorded, transcribed and analyzed for themes using an iterative process. Here, we focus on how nurses manage perceived conflict between disciplinary expectations and abortion work.

**Results:** Nurses in this study expressed both positive emotions (pride, satisfaction, making a difference) and negative emotions (stress, anxiety, exhaustion) associated with their work in abortion care. None referenced perceived role stress as nurses or stated that they did not feel they were caring for their patients, although several did mention complex personal emotions related to abortion.

**Conclusions:** Nursing has codified and studied caring as a key disciplinary value. In nursing discourse around pregnancy, the emphasis has been that the nurse has two patients, not one. Using this construct, the "caring paradox" argues that nurses who participate in abortions are violating a key nursing value. The content themes and evaluations of nurses in this study did not support the idea of a "caring paradox," and instead suggest a more flexible conceptualization of caring, focused on the woman and her needs, rather than on the woman and fetus as patients.

## P13

### BURNOUT, STIGMA AND TEAM COHESION AMONG ABORTION PROVIDERS PARTICIPATING IN THE PROVIDERS SHARE WORKSHOP

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**Objectives:** The Providers Share Workshop is a five-session group workshop designed to address the psychosocial burdens associated with abortion work. We wished to determine the impact of the workshop on quality of life, coping with stress, stigma, social support and team cohesion.

**Methods:** We conducted a multi-site Providers Share Workshop study in 2010–2012. Surveys were administered before and after the workshop to 79 participants and included questions on demographics and five previously-validated measures: professional quality of life, ways of coping, subset of the workgroup characteristics measure, people and organizational culture profile, and abortion provider stigma survey. Analyses included paired *t* tests of scale scores, reliability analyses, regression and factor analysis, using STATA 12.

**Results:** Compared with established norms among other health care workers, abortion providers report higher than average compassion satisfaction (38.7, S.D. 9), and lower than average burnout (14.9, S.D. 6.4) and compassion fatigue (10.5, S.D. 5.7), with no differences after participation in the workshop. Coping with stress was different before and after the workshop: After participation, workers were less likely to engage in confrontive strategies (e.g., anger) ( $t=2.78, p<.004$ ). Experiences of stigma predicted lower compassion satisfaction, higher burnout and higher trauma, after controlling for demographic variables. Positive organizational culture and sense of team were high before and after the workshop.

**Conclusions:** As of baseline, the abortion-providing workforce is highly satisfied, experiences lower burnout and trauma than other health care professions, and functions as a team. Experiences of stigma were the only predictors found to predict lower compassion satisfaction, higher burnout and trauma. Participation in the Providers Share Workshop was associated with changes in some elements of how workers coped with work-related stress.