Touchy Subjects
teaching about abortion
in medical schools and hospitals

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After abortion law reform

The “septic” ward closed & maternal mortality fell
Fertility dropped below replacement (1 daughter per woman)
Adoption evaporated
Family Planning doctors provided pill scripts
“Women’s health” expanded to shelters, rape crisis centers & women’s community health centers
Women were (still) considered “unsuitable” to be specialists
Doctors guarded women’s virtue > many refused to refer for abortion
Attention focused on the tragedy of infertility and heroic/scientific efforts to overcome it

“Abortionist” was a derogatory term
Impact of abortion stigma on medical practitioners in late 20th century

- Recruitment/staffing/relieving was difficult
- Demand outstripped supply
- Conscientious objection obstructed basic service provision
- Women treated with contempt by doctors
- Abortion providers treated with distain
- Students and trainees “protected” from information & clinical training
Values are shifting in the 21\textsuperscript{st} Century

- Premier apologised to 17,500 women whose babies were removed in SA hospitals
- LARCs, then abortion medications listed on the PBS
- Medical women and parents of medical students practice family planning
- Fertility kept falling – and falling
- 90\% of RANZCOG trainees are now women
- RACS is running a “Respect” campaign against bullying
How do all these changes affect medical education?

• Conscientious objectors are losing their grip
• There are more teaching materials about abortion available on the www (TEACH)
• Control over what medical students & trainees are permitted to hear is still controlled by senior clinicians who trained last century
• The content of clinical teaching remains tightly controlled
If providing education & positive role models to medical students & junior doctors is an antidote to ignorance, prejudice & stigma;

• How can we ever get to talk to them?
• What do we want to tell them?
• How can we protect them from bullying & harassment?
How can abortion providers get training to their younger colleagues?

• Find a medical educator who wants to tell the truth > hand them useful teaching tools

• Find an ally > offer to provide content yourself
  – Clinical attachment
  – Research supervision
  – Visiting expert/single lecture
  – Hands on workshop

• Ask a medical educator about the problems they face > offer to help
Education in the recreational space

• Volunteers > fewer of them + most motivated
• AMSA, medical students clubs & societies, Student Union Gender Equity Officer
• Medical Students for Choice
• Asia Safe Abortion Partnership
• Fund a student to attend a conference
• Students are distracted by many things – rotations, exams, broken hearts, graduation
• Rapid turnover > new campaign every year
Teaching in the curriculum

• Compulsory > more care with messaging

• What does EVERY doctor need to know?
  – Abortion is lawful
  – Abortion is safe
  – Abortion access augments public health
  – It is not ethical to prevent women from seeking abortions

• Where can these messages be inserted?
How does anything useful ever get into the curriculum anyway?

• AMC is the accreditation body
• The university decides what it wants taught & employs academics to deliver the content
• There are never enough academics with enough time to attend to everything > volunteering is effective (as long as you are qualified/accredited/credentialed/have a position)
• There are many “blind spots” eg ultrasound
There are multiple curriculums

- School of medicine
- Hospital wide program for junior residents
- Departmental teaching program(s)
- RANZCOG ITP
- Dip Obs & Advanced Dip Obs workbooks
- GPs require 150 CME points every 3 yrs
Once you find a forum what do you want to say?

- Many medical students are obsessed with getting the skills they will need in clinical practice
  - Using ultrasound
  - Inserting LARCs
  - Uterine evacuation (MVA/D&C) using surgical instruments
- They want to be admired (not despised) for their work
  - Human rights, ethical conduct, public health
  - You may want to warn about bullying
- They enjoy rehearsing solutions to problems they may face one day
  - Anecdotes from ED
  - Case like someone they may meet one day
Case

• 23 year old G2P0 from Liberia
• Immigrated 9 months previously
• Obs Hx – 1 x TOP 2008 1 x TOP 2009
• Referred by GP to Gynae clinic with a 1 year history of RUQ when menstruating and dysmenorrhoea
• USS requested by GP reported as “likely calcified retained products in endometrial cavity”
• Booked for elective hysteroscopy, D & C
Operative report

Female genital mutilation: removal of the clitoris and the labia minora, no narrowing of vaginal introitus
Normal sized AV uterus
No adnexal masses
Endometrial cavity containing ? contraceptive device in left cornu
Remainder of cavity normal
Right ostia seen
Left ostia not seen secondary to device
Operation abandoned.
What does this do?

- Fascinating view inside a body
- A diagnostic detective story
- Shocking conduct by abortion provider
- Move from “abortion is a bad thing” to “bad laws cause bad things”
- Suggests that abortion could be life saving surgery
- Illustrates the value of medical education

“if you have ever done a bimanual pelvic exam and caught a uterus between your two hands, you will never do what that practitioner did. You will never put something 50 cm long into a uterine cavity that is 7cm long. You just wouldn’t – because you know so much more about anatomy and how big a uterus really is.”
Effect of legislation

Figure 2. Number of maternal deaths to 100 000 live births, by year, Romania, 1960–1996

Source: World health statistics report
Global, regional, and national levels and causes of maternal mortality
Global Burden of Disease Study 1990–2013: - abortion deaths = light blue
You support women’s self determination – how can you address dissenting views?

• Many in your audience have NEVER heard abortion talked about in practical terms
• Acknowledge that they may not have the same values you do. “You are at the point in your career where you are developing your own professional values”
• Invite them to suggest reasons why there are so many unplanned pregnancies.
• Any who offer a constructive perspective – give positive feedback “Yes, I think that is true”
• Offer facts
Climate change is gathering pace

• There is a more receptive audience
• Abortion providers are more willing to assert their clinical expertise
• Opportunities to provide education to medical students, junior medical practitioners or GPs come and go
• We have seen enough of these opportunities to formulate optimisation strategies
Optimise your chance of imparting truthful information about abortion to trainees

- Consider what kind of teaching you can offer in your workplace? where they are? can you get status/access to medical education forums?

- Study your faculty/college/CME program any existing forum you could join? any professional medical educator who is an ally? – Do they have any problem/gap that you can assist with? – Do they want any teaching tools/materials that you could hand on?

- Assert your expertise
  Abortion providers are expert in preventing unplanned pregnancy, early pregnancy assessment, ultrasound and the public health benefits of reproductive self determination
  – Apply for teaching status with your college/nearest university/GP training provider/Family Planning
Abortion providers remember
You always make sure that you do a good job
if you offer yourself as a role model
to early career practitioners
your attitude is a gift that you can pass on
They listen attentively to every word you say.
It can be quite flattering