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ARTICLE

# Knowledge on medical abortion among Brazilian medical residents in Gynecology and Obstetrics

## Conhecimento de médicos residentes em Ginecologia e Obstetrícia sobre o aborto medicamentoso

## Conocimiento de médicos residentes en Ginecología y Obstetricia sobre el aborto con medicamentos

*Rodolfo de Carvalho Pacagnella* [1]
*Silvana Ferreira Bento* [2,3]
*Karayna Gil Fernandes* [1,4]
*Danielle Miyamoto Araújo* [1]
*Isabela Dias Fahl* [3]
*Tatiana de Figueiredo Fanton* [2]
*Tatiana Benaglia* [5]
*Maria José Duarte Osis* [1,4]
*Graciana Alves Duarte* [2]
*Karla Simônia de Pádua* [2,3]
*Anibal Faúndes* [1,2]
*Grupo de Estudos sobre Aborto no Brasil* [6]

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## Abstract

*Medical or drug-induced abortion has been proven as an effective means for termination of pregnancy. However, training of providers in the use of misoprostol has been limited. The current article aims to identify the degree of knowledge on medical abortion among Brazilian medical residents in Gynecology and Obstetrics. A multicenter cross-sectional study was performed with residents regularly enrolled in residency programs in Gynecology and Obstetrics in 21 teaching hospitals. A self-responded questionnaire was used. Correct responses to each of the alternatives were identified, and a binary response variable (≥ P70, < P70) was defined by the 70th percentile of the number of questions on misoprostol. Four hundred and seven medical residents returned the questionnaire, of which 404 were completed and three were blank. The majority (56.3%) of the residents were 27 years or younger, females (81.1%), and single or not living with a partner (70%). Two-thirds (68.2%) were in the first or second year of residency. Only 40.8% of the participants answered 70% or more of the questions correctly. In the multivariate analysis, enrollment in the third year of residency or greater (OR = 2.18; 95%CI: 1.350-3.535) and having participated in treatment of a woman with induced or probably induced abortion (OR = 4.12; 95%CI: 1.761-9.621) were associated with better knowledge on the subject. Among Brazilian medical residents in Gynecology and Obstetrics, knowledge on medical abortion is very limited and poses an obstacle to proper care in cases of legal termination of pregnancy.*

*Legal Abortion; Abortion; Knowledge; Hospital Medical Staff*

**Correspondence**
*R. C. Pacagnella*
*Departamento de Tocoginecologia, Faculdade de Ciências Médicas, Universidade Estadual de Campinas.*
*Rua Alexander Fleming 101, Cidade Universitária, Campinas, SP 13083-880, Brasil.*
*rodolfop@g.unicamp.br*

*[1] Faculdade de Ciências Médicas, Universidade Estadual de Campinas, Campinas, Brasil.*
*[2] Centro de Pesquisas em Saúde Reprodutiva de Campinas, Campinas, Brasil.*
*[3] Hospital da Mulher "Professor Doutor José Aristodemo Pinotti", Universidade Estadual de Campinas, Campinas, Brasil.*
*[4] Faculdade de Medicina de Jundiaí, Jundiaí, Brasil.*
*[5] Instituto de Matemática, Estatística e Computação Científica, Universidade Estadual de Campinas, Campinas, Brasil.*
*[6] Other members listed at the end of the paper.*

## Introduction

According to estimates, from 2010 to 2014 there were 25.1 million unsafe abortions in the world, of which 24.3 million occurred in developing countries [1]. In Brazil, based on the *National Survey on Abortion* in 2016 (PNA 2016), nearly one out of five Brazilian women had undergone an abortion by age 40 [2]. In countries like Brazil with legal restrictions, clandestine abortion is practiced by women of all social and economic levels, but the consequences are most severe for those living in situations of social vulnerability (low schooling, low income, young age, and single marital status), given the precarious health conditions in which such abortions are performed [2,3]. The World Health Organization (WHO) classified this type as unsafe abortion [4]. An assessment of the situation with unsafe abortion in Brazil from 1996 to 2012 found a slight downward trend, but with an average of close to a million unsafe abortions a year [5].

The late 20th century witnessed the possibility of medical (non-surgical) termination of pregnancy, initially with antiprogestin alone and later in combination with a uterotonic agent or with uterotonic agents alone [6,7,8]. Medical or drug-induced abortion has proven to be an effective means for termination of pregnancy [9,10,11].

Misoprostol has been used in Brazil since the late 1980s [12], and evidence shows that its use has contributed to a reduction in the incidence of serious post-abortion complications [13,14,15].

Over the course of this text, the term abortion will be used as in common practice. In Brazil, Ministry of Health technical protocol entitled *Atenção Humanizada ao Abortamento* [16] provides that women who request legal termination of pregnancy should be offered the choice between medical abortion with misoprostol or surgical abortion.

However, training of providers in the use of misoprostol has been limited. The unavailability of medical abortion is thus a relevant factor, since many Brazilian gynecologists and obstetricians who would not be willing to perform a legal termination of pregnancy by aspiration would perform the abortion if it meant prescribing misoprostol [17].

Teaching on abortion and particularly on the various techniques for termination of pregnancy is limited or even non-existent in schools of medicine, even in developed countries like the United States or Canada [18,19]. Residents in programs that include training on routine abortion have proven more willing than others to provide abortion. We have found no similar studies in Brazil, but there is nothing to suggest that the situation is different from that described in North America. Given this scenario, the current article aimed to identify the degree of knowledge of Brazilian medical residents in Gynecology and Obstetrics on medical abortion, since they will soon be initiating their professional practice.

## Methods

A multicenter cross-sectional study was performed with residents regularly enrolled in the medical residency program in Gynecology and Obstetrics in 21 teaching hospitals in Brazil, some of which were affiliated with universities. All of the hospitals were part of the Brazilian Network of Reproductive and Perinatal Health Studies (REDE) and were tertiary services for referral of high-complexity cases and performed more than 2,000 deliveries a year. There were ten state hospitals, seven federal, two municipal, and two Mercy Hospitals. Data were collected from February 2015 to January 2016.

During the data collection at the 21 hospitals, there were 530 physicians enrolled in the medical residency in Gynecology and Obstetrics. This number represents 30.2% of the 3,018 physicians enrolled in the medical residency in this same specialty in Brazil in the year 2017 [20].

Data collection used a self-completed questionnaire with 30 closed questions, with possible responses or a Likert scale and an open question for spontaneous comments on the topic. The questionnaire contained variables on sociodemographic characteristics, opinions on situations in which abortion should be legal, whether the individual had received classes on medical abortion during undergraduate medical training and on the use of misoprostol and mifepristone during the residency, knowledge on misoprostol and mifepristone, the advantages and disadvantages for women of medical abortion versus surgical abortion, treatment practice for women who had undergone an induced or probably induced abortion, and whether the resident had participated in a legal termination of

pregnancy, in addition to the residents' willingness to perform an abortion on women under certain situations in the future.

In each of the hospitals, a local supervisor was identified who invited all the residents to participate in the study. Residents were individually or in small groups, according to the assessment of the academic and/or administrative authorities as most appropriate in each hospital. This was because the research topic is controversial and might embarrass the resident. Supervisors were asked to have a list of the residents' names to check who had been approached and who had not, in order to invite everyone. Supervisors were also instructed to destroy the list after inviting or attempting to invite all the residents.

Supervisors were responsible for informing the residents of the study's objectives, that their participation would be voluntary, and that they would not be identified by name, since the questionnaire did not request any such information. They were also instructed to give residents the Instructions and Responsibility Form and tell them to read it and keep this document with them, answering any questions concerning the study in case they had any doubts and explaining that the anonymous self-responded questionnaire (whether completed or not) should be deposited in a previously sealed box for this purpose The purpose of these instructions was to guarantee the residents' privacy, so that if necessary they could decline from completing the questionnaire without any fellow resident or even the supervisor knowing.

The questionnaire was given to the residents together with the Instructions and Responsibility Form, and the supervisor informed them of the place where the box would be available for them to deposit the questionnaire, and for how long. The residents were instructed not to consult any reference materials while completing the questionnaire.

The deadline for depositing the questionnaires in the box was one to two weeks. The sealed boxes were sent to the study's coordinating institution, and the questionnaires were numbered, reviewed, digitized, and filed.

The free and informed consent form was waived by the Institutional Review Board, considering the study topic's characteristics and the way anonymity was guaranteed. However, in order to inform participants, the Instructions and Responsibility Form was prepared, containing the same information as a free and informed consent form, and given to the potential volunteers together with the questionnaire. The project was approved by the Institutional Review Board of the Department of Obstetrics and Gynecology of the State University of Campinas (Unicamp) and the Ethics Research Committee (CEP) of the Office of the Dean of Research of Unicamp (protocol CAAE: 21177013.3.0000.5404), besides having received approval from the CEP of the respective participating centers.

For questions on knowledge pertaining to medical abortion, participants who reported having received information on this type of abortion during their residency training were instructed to answer a question on the use of misoprostol and another on mifepristone. The resident was instructed to check the column for each statement, whether true, false, or unsure.

For the data processing, the correct responses to each of the alternatives were identified, and each phrase that the resident answered correctly was assigned a value of 1 (one), while the incorrect and "unsure" answers were assigned a value of 0 (zero). A binary response variable (≥ P70, < P70) was defined according to the 70$^{th}$ percentile of the number of questions on misoprostol. The total number of questions on misoprostol was 8, and thus the 70$^{th}$ percentile was 5.6. Therefore, residents that answered 6, 7, or 8 questions correctly were classified as having correct knowledge ≥ P70; otherwise, their knowledge was classified as < P70. Analysis of this variable used simple and multivariate logistic regression, presenting the odds ratios (OR) and 95% confidence intervals (95%CI).

Data were keyed in directly on electronic forms, and the data's consistency was checked. All the digitization and verification procedures used the data entry module of the SPSS (https://www.ibm.com/). The statistical analyses used SAS (version 9.4) (https://www.sas.com/).

## Results

There were 530 medical residents in Gynecology and Obstetrics in the 21 hospitals at the time of the data collection. Four hundred and forty residents were approached by their supervisors and invited to participate in the study. Of these, 407 returned the questionnaires, 404 of which were completed and three were blank. Ninety residents were not invited by their supervisors to participate in the study either because they were assigned to other health units at the time or were working on different shifts from the supervisor, and were thus not located during the data collection period.

More than half of the residents in the sample were 27 years or younger, and four-fifths were women. Slightly more than two-thirds were single (without partner) and were in the first or second year of residency at the time of the interview (Table 1). About 60% were born in the South and Southeast regions of Brazil and had done their undergraduate medical training in these same regions (Table 1).

More than two-thirds (68.3%) were doing their medical residencies in hospitals affiliated with universities (data not shown in tables).

Four out of five residents professed some religion, and for 37% of them religion was very important in their lives. Fewer than 10% of the residents stated that religion was scarcely important or unimportant (Table 1).

**Table 1**

Distribution of a sample of Brazilian medical residents in gynecology and obstetrics according to sociodemographic characteristics (n = 404).

| Variables | n | % |
|---|---|---|
| Age (complete years) * | | |
| ≤ 27 | 227 | 56.3 |
| ≥ 28 | 176 | 43.7 |
| Sex * | | |
| Female | 327 | 81.1 |
| Male | 76 | 18.9 |
| Marital status * | | |
| Without partner | 282 | 70.0 |
| With partner | 121 | 30.0 |
| Year of medical residency ** | | |
| First or second | 274 | 68.2 |
| Third to fifth | 128 | 31.8 |
| Geographic region of birth | | |
| Southeast | 207 | 51.2 |
| South | 28 | 6.9 |
| North | 35 | 8.7 |
| Northeast | 117 | 29.0 |
| Central | 10 | 2.5 |
| Other countries | 7 | 1.7 |
| Geographic region of undergraduate medical training * | | |
| Southeast | 212 | 52.6 |
| South | 31 | 7.7 |
| North | 40 | 10.0 |
| Northeast | 106 | 26.3 |
| Central | 7 | 1.7 |
| Other countries | 7 | 1.7 |

(continues)

**Table 1 (continued)**

| Variables | n | % |
|---|---|---|
| Religion * | | |
| Catholic | 235 | 58.3 |
| Kardecist | 51 | 12.6 |
| Evangelical/Protestant | 35 | 8.6 |
| Other | 6 | 1.5 |
| None | 76 | 19.0 |
| Importance of religion in the resident's life | | |
| Very important | 121 | 36.8 |
| Important | 176 | 53.7 |
| Scarcely important/unimportant | 31 | 9.5 |
| Participated in treatment of women with induced or probably induced abortion ** | | |
| Yes | 328 | 81.6 |
| No | 74 | 18.4 |
| Participated in legal termination of a pregnancy ** | | |
| Yes | 286 | 71.1 |
| No | 116 | 28.9 |

Note: missing opinion of residents: * 1; ** 2.

Just over 80% of the residents had participated in treatment of women with an induced or probably induced abortion, and just over 70% had participated in the legal termination of a pregnancy (Table 1).

As for medical abortion, 324 participants reported having received classes on the subject during their residency (80.6% of the total sample), and 70% considered this information sufficient. Slightly more than half (52.1%) reported having received classes on medical abortion during their undergraduate medical training. Only 17 residents (3%) said they had received information on the use of mifepristone for abortion (data not shown in tables).

As for correct and incorrect answers by medical residents on the use misoprostol, only 40.8% of the participants answered at least 70% of the questions correctly. The statement on the use of misoprostol and hospitalization of the woman received only a few correct answers. Slightly more than half answered correctly on the administration route, and only one third of the residents answered correctly on the dosage (Table 2).

Residents who were more than 26 years of age and those in the later years of their medical residency were significantly more likely to have better knowledge on the use of misoprostol. Fourth-year residents were nearly four times more likely to have better knowledge of medical abortion than those in their initial years (Table 3). Having participated in care for women with an induced or probably induced abortion and having participated in the legal termination of a pregnancy during medical residency were also associated with better knowledge (Table 4). In the multivariate analysis, being in the third year of residency or higher (OR = 2.18) and having participated in care for a woman with induced or probably induced abortion (OR = 4.12) remained associated with better knowledge on the subject (Table 5).

## Discussion

Knowledge of medical abortion among Brazilian medical residents in Gynecology and Obstetrics is very limited. Although a large proportion of the residents (80.6%) had received information on misoprostol for abortion, when asked specifically about its use and indications in clinical practice, fewer than half answered more than 70% of the questions correctly.

**Table 2**

Correct and incorrect answers by residents on the use of misoprostol (n = 324).

| Statements | False | | True | | Unsure | | Correct (%) |
|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | % |
| 1. The more advanced the gestational age, the higher the dose of misoprostol. | **297** | **93** | 21 | 7 | 3 | 1 | 93 |
| 2. Vaginal administration causes fewer side effects than the oral or sublingual route. | 48 | 15 | **231** | **72** | 41 | 13 | 72 |
| 3. A single dose of 800mcg of misoprostol by the vaginal route is effective and presents less risk and fewer complications. | 175 | 55 | **105** | **33** | 40 | 13 | 33 |
| 4. The best results are obtained by using 400mcg by the oral route and 400mcg by the vaginal route. | **208** | **65** | 18 | 6 | 93 | 29 | 65 |
| 5. Misoprostol by the sublingual route is not effective. | **185** | **58** | 28 | 9 | 106 | 33 | 58 |
| 6. Cramps are a side effect present in most abortions performed with misoprostol. | 18 | 6 | **292** | **92** | 9 | 3 | 92 |
| 7. In most cases, expulsion of the uterine content occurs in the first 24 hours. | 55 | 17 | **235** | **73** | 31 | 10 | 73 |
| 8. Misoprostol can be used without the need to hospitalize the woman with up to nine weeks gestational age. | 166 | 52 | **79** | **25** | 76 | 24 | 25 |

Note: correct answers in bold print.

As expected, the farther along in their residency, the better their knowledge on misoprostol, but fewer than 60% of fourth-year residents got more than 70% of the questions right. The progressive increase in knowledge on this subject as their medical training progresses appears to begin in undergraduate medical school, judging by the findings from a study conducted in students in their final year of school at three universities in São Paulo, in which only one out of five students displayed satisfactory knowledge on this topic [21].

Likewise, having participated in treatment or having performed a legal termination of a pregnancy was associated with better knowledge, corroborating findings by other authors [22]. However, even in the group with this experience, only 45.4% answered more than 70% of the questions correctly, showing that even in this group with better information there were gaps in learning on medical abortion during residency in Gynecology and Obstetrics.

We found no previous publications presenting results of a study that specifically asked Brazilian medical residents in Gynecology and Obstetrics about their knowledge of medical abortion, beside what had already been reported on undergraduate students in their final year of medical school. Since our sample represents 30.2% of all the Brazilian medical residents in Gynecology and Obstetrics in 2017, the results strongly suggest that Brazilian medical schools have not adequately prepared residents to perform non-surgical legal termination of pregnancy, as specified in the official protocol on *Prevenção e Tratamento dos Agravos Resultantes da Violência Sexual Contra Mulheres e Adolescentes* [23], which is also a practice recommended by the WHO [4] and the International Federation of Gynecology and Obstetrics (FIGO) [24] and the Brazilian Ministry of Health [16].

Termination of pregnancy is authorized by Brazilian legislation in the circumstances described previously, and women who meet these conditions should receive treatment without restrictions. If there is a possible treatment for a health condition and the woman is denied access to it, her rights are being violated and the physician is failing to comply with his or her ethical and professional obligations. As the FIGO Code of Ethics states: *"The primary conscientious duty of obstetrician-gynecologists is at all times to treat, or provide benefit and prevent harm to the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty"* [24].

The main cause of the restrictions in Brazil is the stigma attached to abortion [25], a problem that will continue unabated as long as the issue continues to receive so little attention in the country's medical schools. Brazil's schools of medicine need to devise ways to improve medical residents' training in legal abortion and the use of misoprostol. This is because abortion is a common experience in the lives of childbearing-age women and is also one of the most routine surgical procedures performed by gynecologists and obstetricians [26]. In addition, when this type of training is not provided

**Table 3**

Percentage of residents with at least 70% of correct answers on the use of misoprostol, according to sociodemographic characteristics.

| | | | Correct answers ≥ P70 | | |
|---|---|---|---|---|---|
| | n | % | p-value | OR | 95%CI |
| Age (years) | | | | | |
| ≤ 25 | 13/51 | 25.0 | | | |
| 26-27 | 55/125 | 44.0 | **0.024** | 2.297 | 1.116-4.728 |
| ≥ 28 | 64/148 | 43.2 | **0.027** | 2.227 | 1.096-4.524 |
| Sex | | | | | |
| Female | 100/260 | 38.5 | | | |
| Male | 32/63 | 51.0 | 0.076 | 1.652 | 0.950-2.873 |
| Geographic region of birth | | | | | |
| Other geographic region/Country | 78/192 | 40.6 | | | |
| Southeast/South Brazil | 54/132 | 40.9 | 0.959 | 1.012 | 0.645-1.588 |
| Geographic region, undergraduate training | | | | | |
| Other geographic region/country | 80/199 | 40.2 | | | |
| Southeast/South Brazil | 52/125 | 41.6 | 0.803 | 1.06 | 0.672-1.670 |
| Current year of residency | | | | | |
| First | 23/91 | 25.0 | | | |
| Second | 44/114 | 38.6 | **0.045** | 1.858 | 1.015-3.402 |
| Third | 50/95 | 53.0 | **0.001** | 3.285 | 1.765-6.113 |
| Fourth or more | 12/21 | 57.0 | **0.006** | 3.942 | 1.472-10.557 |
| Marital status | | | | | |
| With partner | 45/98 | 46.0 | | | |
| Without partner | 86/225 | 38.2 | 0.196 | 0.729 | 0.451-1.177 |
| Importance of religion | | | | | |
| Very important | 39/98 | 40.0 | | | |
| Important, scarcely important, unimportant | 93/226 | 41.2 | 0.820 | 1.058 | 0.652-1.715 |

95%CI: 95% confidence interval; OR: odds ratio.

Note: simple logistic regression in which the response variable is the resident's knowledge.

to future gynecologists and obstetricians, women are deprived of their rights according to the basic principles of bioethics (autonomy, beneficence/nonmaleficence, and justice).

The standards regulating care for legal abortion in Brazil determine that the attending health professionals should provide humanized care to the woman, besides addressing the indication of misoprostol for termination of the pregnancy or uterine evacuation [16]. However, the official guidelines do not suffice if the providers (gynecologists and obstetricians in Brazil's case) are not adequately trained in the procedures.

One proposal for educating professionals is the use of active methodologies in medical schools. This type of teaching/learning methodology is student-centered, where the professor acts as a facilitator of the knowledge. Small groups of students conduct a discussion on the knowledge to be built based on real cases. The method allows involving both basic knowledge and more advanced knowledge and promoting a critical discussion of cases. There is good experience with the use of this active methodology, especially in the improvement of skills performance and critical reasoning [27]. Another technique that has been used is role-playing, which allows "switching roles" between the actors involved in the same theme so that they can perceive different points of view on one theme, that is, from different perspectives [28].

Meanwhile, our results show that care for cases of legal abortion and incomplete abortion by residents was associated with better knowledge on the use of misoprostol, suggesting that if all medical

**Table 4**

Distribution of characteristics on medical practice and teaching according to knowledge on the misoprostol.

| | | | Correct answers ≥ P70 | | |
|---|---|---|---|---|---|
| | n | % | p-value | OR | 95%CI |
| Classes on medical abortion during undergraduate medical training | | | | | |
| No | 51/131 | 38.9 | | | |
| Yes | 81/192 | 42.2 | 0.559 | 1.145 | 0.728-1.801 |
| Consider information received during residency sufficient | | | | | |
| Unsure | 8/25 | 32.0 | | | |
| Insufficient | 19/67 | 28.0 | 0.7335 | 0.841 | 0.311-2.274 |
| Sufficient | 103/226 | 45.6 | 0.1994 | 1.779 | 0.738-4.291 |
| Participated in treatment of women with induced or probably induced abortion | | | | | |
| No | 8/47 | 17.0 | | | |
| Yes | 124/274 | 45.3 | **0.0006** | 4.030 | 1.816-8.942 |
| Participated in performing legal termination of a pregnancy | | | | | |
| No | 19/72 | 26.0 | | | |
| Yes | 113/249 | 45.4 | **0.0045** | 2.318 | 1.297-4.141 |
| Abortion should be legalized | | | | | |
| Yes, in any situation | 10/25 | 40.0 | | | |
| No, in any situation | 114/286 | 39.9 | 0.9891 | 0.994 | 0.432-2.29 |
| No opinion | 6/10 | 60.0 | 0.2884 | 2.250 | 0.504-10.053 |

95%CI: 95% confidence interval; OR: odds ratio.

Note: simple logistic regression in which the response variable is the resident's knowledge.

**Table 5**

Multivariate logistic regression in relation to the explanatory variables for better knowledge on use of misoprostol.

| Effect | OR estimates | 95%CI * | p-value |
|---|---|---|---|
| Current year of residency: third or more versus first or second | 2.184 | 1.350-3.535 | **0.002** |
| Participated in care for induced or probably induced abortion (yes vs. no) | 4.116 | 1.761-9.621 | **0.001** |

95%CI: 95% confidence interval; OR: odds ratio.

Note: multiple logistic regression considering all the other variables in the model.

* Wald test.

schools provided services for legal termination of pregnancy, residents would be better prepared for this practice, while access to these services would be expanded in Brazil.

Using active methodologies for teaching on legal abortion and termination of pregnancy would be an important strategy, since students could be the protagonists in the discussions in the search for knowledge and case-solving. At any rate, it is important to have a space for discussion in the medical residency curriculum that involves gender issues and rights, since these health professionals will be caring for women that are experiencing abortion in the near future and will be opinion-makers on the issue.

One limitation to this study was that the question on knowledge of misoprostol was only answered by residents who reported having received classes on medical abortion. A person's acquisition of knowledge is not associated only with didactic classes they attend, but with all kinds of information

they receive through existing communications media. Students currently have easy access to books, scientific journals, bulletins, and newsletters, and interact with others on social networks. We lacked information on this point, the subject of this article, for 22.3% of the total sample.

The study's results show that among Brazilian medical residents in Gynecology and Obstetrics, knowledge on medical abortion is very reduced and poses an obstacle to proper care in cases of legal termination of pregnancy.

Unplanned pregnancy and induced abortion have been present in all societies throughout history and have been acknowledged and addressed. The most efficient solution is legalization of abortion, which not only leads to rapid reduction of morbidity and mortality, but also contributes to the reduction of the abortion rate [29]. Until this happens, it is up to physicians to ensure that every woman who meets the conditions allowed by law will have easy access to services for legal termination of pregnancy, particularly the poor and unprotected, who are treated at public services, because they are the ones that suffer the worst consequences of clandestine abortion [4]. Physicians' capacity to correctly provide medication for the termination of pregnancy is a factor that has proven to be of the utmost importance to facilitate access to legal abortion [30].

We hope that the publication of these results will help call the attention of health authorities and medical societies to the need to correct this unfortunate gap in training medical residents in Gynecology and Obstetrics.

## Contributors

R. C. Pacagnella and A. Faúndes conducted the study and participated in the conception, data analysis and interpretation, writing of the manuscript, and final approval. S. F. Bento, K. G. Fernandes, K. S. Pádua, T. F. Fanton, T. Benaglia, I. D. Fahl and M. J. D. Osis contributed to the data analysis and interpretation, writing of the manuscript, and critical revision for the final approval. G. A. Duarte and D. M. Araújo in the conception, research planning and critical revision of the manuscript for its final approval.

## Additional informations

ORCID: Rodolfo de Carvalho Pacagnella (0000-0002-5739-0009); Silvana Ferreira Bento (0000-0003-3048-2250); Karayna Gil Fernandes (0000-0003-4014-6277); Danielle Miyamoto Araújo (0000-0001-6080-3196); Isabela Dias Fahl (0000-0003-4275-8031); Tatiana de Figueiredo Fanton (0000-0002-5610-4154); Tatiana Benaglia (0000-0003-4111-3864); Maria José Duarte Osis (0000-0003-3625-1525); Graciana Alves Duarte (0000-0003-3979-3944); Karla Simônia de Pádua (0000-0001-7365-5161); Aníbal Faúndes (0000-0003-4178-6030).

## Other members of the Grupo de Estudos sobre Aborto no Brasil

Carlos Augusto Santos de Menezes, Claudio Sérgio Medeiros Paiva, Dênis José do Nascimento, Edilberto Alves Pereira Rocha da Silva, Elaine Christine Dantas Moisés, Fátima Aparecida Henrique Lotufo, Fernando Artur Carvalho Bastos, Francisco Edson de Lucena Feitosa, Francisco José Machado Viana, Francisco Lázaro Pereira de Sousa, Ione Rodrigues Brum, Joaquim Luiz de Castro Moreira, Marcelo Marques de Souza Lima, Mário Dias Côrrea Júnior, Marla Niag dos Santos Rocha, Nelson Sass, Olímpio Barbosa de Moraes Filho, Rosiane Mattar, Silvana Maria Quintana, Vera Therezinha Medeiros Borges, Yalli Coelho.

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## Resumo

*O aborto medicamentoso ou farmacológico tem demonstrado ser um meio eficaz para a interrupção da gravidez. Entretanto, o treinamento de provedores no uso do misoprostol tem sido limitado. O presente artigo tem como objetivo identificar o grau de conhecimento dos médicos residentes em Ginecologia e Obstetrícia sobre aborto medicamentoso. Realizou-se um estudo transversal multicêntrico com residentes regularmente inscritos no programa de residência em Ginecologia e Obstetrícia de vinte e um hospitais de ensino. Foi utilizado um questionário de autorresposta. As respostas corretas a cada uma das alternativas foram identificadas e uma variável de resposta binária (≥ P70, < P70) foi definida pelo percentil 70 do número de perguntas sobre o misoprostol. Quatrocentos e sete médicos residentes devolveram o questionário, sendo que 404 estavam preenchidos e três em branco. A maioria (56,3%) dos residentes tinha até 27 anos de idade, era do sexo feminino (81,1%) e não vivia junto com um(a) companheiro(a) (70%). A maior proporção (68,2%) estava cursando o primeiro ou segundo ano da residência. Apenas 40,8% dos participantes acertaram 70% ou mais das afirmativas. Na análise múltipla, cursar o terceiro ano de residência ou superior (OR = 2,18; IC95%: 1,350-3,535) e ter participado do atendimento a uma mulher com abortamento induzido ou provavelmente induzido (OR = 4,12; IC95%: 1,761-9,621) mostraram-se associados a um maior conhecimento sobre o tema. Entre os médicos brasileiros residentes em Ginecologia e Obstetrícia, o conhecimento sobre o aborto medicamentoso é muito reduzido e constitui um obstáculo para o bom atendimento dos casos de interrupção legal da gestação.*

*Aborto Legal; Aborto; Conhecimento; Corpo Clínico Hospitalar*

## Resumen

*El aborto con medicamentos o farmacológico ha demostrado ser un medio eficaz para la interrupción del embarazo. No obstante, la capacitación de los médicos en el uso del misoprostol ha sido limitada. El objetivo de este artículo es identificar el grado de conocimiento de los médicos residentes en Ginecología y Obstetricia sobre el aborto con medicamentos. Se realizó un estudio transversal multicéntrico con residentes regularmente inscritos en el programa de residencia en Ginecología y Obstetricia de veintiún hospitales de enseñanza. Se utilizó un cuestionario de autorrespuesta. Las respuestas correctas de cada una de las alternativas fueron identificadas y una variable de respuesta binaria (≥ P70, < P70) se definió por el percentil 70 del número de preguntas sobre el misoprostol. Cuatrocientos siete médicos residentes devolvieron el cuestionario, siendo que 404 estaban cumplimentados y tres en blanco. La mayoría (56,3%) de los residentes tenía hasta 27 años de edad, eran de sexo femenino (81,1%); no vivía junto a un(a) compañero(a) (70%). La mayor proporción (68,2%) estaba cursando el primero o segundo año de residencia. Solamente un 40,8% de los participantes acertaron un 70% o más de las afirmaciones. En el análisis múltiple, estar en el tercer año de residencia o superior (OR = 2,18; IC95%: 1,350-3,535) y haber estado implicado en la atención a una mujer con aborto inducido o probablemente inducido (OR = 4,12; IC95%: 1,761-9,621) se mostraron asociados a un mayor conocimiento sobre el tema. Entre los médicos brasileños residentes en Ginecología y Obstetricia, el conocimiento sobre aborto con medicamentos es muy reducido y constituye en obstáculo para una buena atención de los casos de interrupción legal de la gestación.*

*Aborto Legal; Aborto; Conocimiento; Cuerpo Médico de Hospitalares*

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