Teaching and Learning in Nursing 17 (2022) 229–232

Contents lists available at ScienceDirect

Teaching and Learning in Nursing

journal homepage: www.journals.elsevier.com/teaching-and-learning-in-nursing

Implementation of an interprofessional health education course on abortion care

Martha Paynter, RN, PhDc[a,b,d,*], Danielle LeBlanc, RN[b], Lianne Yoshida, MD[b], Anna Finlayson, MSW[b], Kristen Turtle, RN[b], Marion Brown, PhD[c], CJ Blennerhassett, RM[d], Laurie Graham, NP[a]

[a] Dalhousie University School of Nursing, Halifax, Nova Scotia, Canada
[b] Nova Scotia Women's Choices Clinic, IWK Health Centre, Halifax, Canada
[c] Dalhousie University School of Social Work, Halifax, Canada
[d] IWK Health Centre, Halifax, Canada

ARTICLE INFO

Keywords:
Abortion
Canada
Contraception
Health policy
Interprofessional health education

ABSTRACT

Background: Content on abortion history and methods is notably absent from many health care education programs in Canada. A team of multi-disciplinary professionals and academics launched a minicourse on abortion at a Canadian university as part of the interprofessional education requirement for health professional students. The minicourse covered the legal history of abortion in Canada, clinical guidelines for medication and aspiration abortion, socio-emotional and therapeutic support, and information on contraception.
Results: Students gained knowledge through both didactic instruction and small group discussion, giving attendees an opportunity to understand their role in supporting patients in collaboration with other health professionals. In response to student feedback, facilitators added content about Indigenous and LGBTQ+ health to the course.
Conclusion: Students learned the clinical content and history of abortion with their peers through a framework of social determinants of health. The course will continue to adapt to reflect best practices and socio-political changes.

Introduction

Abortion is a common reproductive health experience for people in Canada, with approximately 100,000 abortions occurring annually (Canadian Institutes of Health Information, 2017). The approval of medication abortion (mifepristone) by Health Canada in 2015 presented a significant opportunity for improving access (Health Canada, 2015). In 2017, non-physician prescribers including nurse practitioners (NP) were authorized to prescribe mifepristone (Health Canada, 2017), potentially improving access further. However, medication abortion prescribing is not routinely taught in NP training programs, nor is abortion a regular part of undergraduate nursing education, or that of most other health professions (Paynter et al., 2019). Despite the complete decriminalization of abortion in Canada more than 30 years ago (Morgentaler [1988] 1 SCR 30), significant barriers to abortion access remain, including a shortage of willing, trained providers (Shaw, 2019) and limited access in rural and remote areas (Norman et al., 2016). Health care professionals and students across disciplines lack opportunities to learn about their roles in abortion care. The purpose of this paper is to describe an educational innovation that models integration of abortion care into nursing and interprofessional education. The intended audience of this paper are nurse educators, and educators colleagues in other health professional schools.

Background

In 2020, we responded to a call at our local University for the creation of interprofessional education (IPE) mini-courses with a proposal that invited students across the health professions to learn about abortion care together. IPE courses are an opportunity for students from a variety of disciplines to clarify the roles of their professions with each other, develop understanding and skills in collaborative team functioning and collaborative leadership, practice communication and conflict resolution, and work towards patient-and-community-centered care (Canadian Interprofessional Health Collaborative, 2010). All entry-to-practice health profession students at X University are required to participate in interprofessional education courses

*Corresponding author.
E-mail address: Mpaynter@dal.ca (M. Paynter).

https://doi.org/10.1016/j.teln.2021.10.007
1557-3087/

during each year of study. While the abortion course itself is not mandatory, it fulfills a mandatory requirement.

Our team included local abortion clinic nurses, a clinic family physician, a clinic social worker, and nursing, nurse practitioner and social work faculty from the university. Team members' expertise included abortion care, reproductive justice, interpersonal communication, advocacy, resource facilitation, and facilitating interprofessional education. Due to COVID-19, our plans for in-person interprofessional learning and practical exposure for students to the clinic environment were adjusted to take place online. We first offered the course in the fall of 2020 and again in 2021.

Overview of the Interprofessional Education and Practice (IPEP) Activity

The course modules included information about the legal history of abortion and the current regulatory environment; overview of medication and aspiration abortion; the role of socio-emotional therapeutic support in abortion care; and contraception options. The sessions were all synchronous. Each session began with a didactic presentation which encouraged questions either verbally or through the chat function in the online learning platform. For the second half of the session students and facilitators moved into online small groups to share reflections and analysis on case scenarios.

Legal History

Exposure to negative United States news media about abortion restrictions can overshadow understanding of how access to abortion works in Canada. We presented a brief overview of key historical moments such as the Criminal Law Amendment Act (Dunsmuir, 1998), when abortion was decriminalized if a committee of medical practitioners determined it was necessary for the patient's health; the Morgentaler decision (Morgentaler [1988] 1 SCR 30), when abortion was completely decriminalized; and relevant cases including Tremblay v Daigle (Tremblay v Daigle [1989] 2 S.C.R. 530), R v Sullivan (Sullivan [1991] 1 S.C.R. 489), and Dobson v Dobson (Dobson (Litigation guardian of) v Dobson, [1999] 2 SCR 753) that clarified the fetus does not have legal rights in Canada. We discussed recent events in our region of Canada, which has experienced several regulatory shifts since 2014.

Medication and Aspiration Abortion

In the second session we gave a brief overview of the clinical aspects of both aspiration (Costescu & Guilbert, 2018) and medication abortion (Costescu et al., 2016). As mifepristone was only approved in Canada in 2015 and made available on the market in 2017, the practical aspects of its use are new information for many people, including health profession students. Stigma and secrecy also prevent students and the public from understanding the steps in procedural. For example, we are moving away from the language of "surgical" abortion because the term inappropriately suggests cutting and a requirement for general anesthesia.

We developed five case studies for the students to discuss in their small groups and consider how medication or aspiration abortion might work for different patients in the context of their lives.

Socio-Emotional Therapeutic Support

The third session focused on person-centered care that emphasizes social and structural determinants of health and the importance of attending to the psych-social, mental wellness aspects of a patient's experience. A patient's position relevant to employment, literacy, racial discrimination, and access to health services brings shape to their capacity for coping and access to social supports (Solar & Irwin, 2010). It is important for those providing therapeutic support to view individual circumstances through this macro lens. Furthermore, stigma, bias, and longstanding judgmental narratives weigh heavily on people facing decisions regarding abortion (LaRoche & Foster, 2018). The role of socio-emotional support must begin with deep listening to and validation of one's story. This session detailed the central role of empathy, trauma-informed principles (Levenson, 2017), and strengths-based support, detailing concrete approaches and verbatim phrases for learners to practice in case scenarios. The scenarios focused on difficult conversations about abuse, poverty, relationship breakdown, and concerns about child safety.

We reviewed psycho-social assessments as part of the social work role in abortion care, and why they are important in both gathering information and determining how best to support patients throughout the abortion process. We reviewed how to approach difficult conversations, the importance of support systems, and local community resources. These resources included shelters, transition houses, substance use support, income assistance, sexual assault support and sexual assault nurse examiner, a university social work clinic, street outreach navigator, and emergency contacts for patients in crisis.

We also reviewed provisions in the provincial Children and Family Services Act (Nova Scotia, 2018) regarding duty to report abuse and federal law governing the age of consent for sexual activity (Canada, 2017). We discussed the high rates of intimate partner and sexual violence in Canada, higher still for members of LGBTQ+ communities and Indigenous people (Simpson, 2018). All types of health professionals should have some comfort addressing trauma and be familiar with local resources. We developed three case studies for small group discussions about supporting patients experiencing abuse, poverty, relationship breakdown, and how to address concerns about child safety.

Contraception

The final session focused on the history of contraception and approaches to contraception counselling and prescription. We began with an overview of early barrier methods and abortifacients (Riddle, 1991), and early adopters and inventors in the advancement of contraception and available reproductive health services. We discussed the racist and eugenicist roots of birth control and family planning to alert students to this complex history, including the forced sterilization of Indigenous women in Canada (Roberts, 1997; Stote, 2017).

We provided an overview of short acting reversible contraception (SARC) versus long acting reversible contraception (LARC) (Hubacher et al., 2015), hormonal versus non-hormonal methods, and the benefits, potential side effects, mechanisms of action, and contraindications for each method. Inclusive language was used throughout, with a special focus on contraception for gender diverse and/or transgender patients (Bonnington et al., 2020). We were also able to introduce knowledge about the contraceptive implant, which became available in Canada the month before the course launched (Grant, 2020).

Other themes explored during the session were barriers to access, such as the financial cost of the different contraceptive methods. Students were given information about the provincial Pharmacare Program and how to assist patients without drug coverage through the process of applying (Nova Scotia, 2021). Local access pathways were examined, such as the sexual health clinic, where to buy birth control at cost, how to obtain emergency contraception, and when to take it. Lastly, we showed a short, educational video of insertion of an intrauterine device (IUD).

Approach to Implementing the Activity

To our knowledge, this four-session course is the first interprofessional course in abortion care in Canada. News media picked up on

this innovation and community response to news about the course was not only overwhelmingly positive but resulted in community members seeking permission to join the program (Smith, 2020). One of the first challenges we encountered was managing demand. We accepted 40 students for the first offering, with 60 students wait-listed.

The second challenge was managing the clinical schedules of participants. Due to COVID-19 and other issues, many of the students learned of required clinical placements that would conflict with the abortion course only after they had registered and/or participated in the first session. We were not prepared for the administrative work of several large adjustments to the class composition.

Due to COVID-19 we were unable to offer students a session in person as we had originally proposed. We used the funding we had received to launch the course to hire a local filmmaker to create a "video tour" of the clinic. Without rehearsing, the team members who are abortion clinic staff worked together one afternoon on this ten minute film. It includes a walk-through of the space starting from the secure entrance, through patient interview rooms, the procedure room, recovery room, and offices. The clinic physician led a brief overview of the equipment and supplies for aspiration abortion, and the nursing staff described the assessment process, medications, and protocols for patient management during and after aspiration abortion.

Informally throughout the course and formally at the end of the course we sought feedback from participants. Among other feedback, some wanted it to be longer, some thought it was the perfect length. The film was a much-appreciated alternative to an in-person tour.

Participants in the course offered valuable insights and suggestions for improvement, including concerns about insufficient and inadequate LGBTQ+ content and questions about Indigenous perspectives. We reflected on and responded to this feedback in planning for the second offering. We are committed to continuously improving the inclusivity and health equity in the course content offered.

We made several changes to the course for the second offering including expansion of the represented professions on the facilitation team to include midwifery. Although the university that hosts the course does not offer a midwifery training program, the students training in medicine, nursing and social work, as well as other health professions such as pharmacy, will work with midwives in their professional lives and early introduction will be of great benefit.

To address concerns about the LGBTQ+ content we reviewed all of our materials to ensure we had removed gendered language. We were also inspired by the students' concerns to address the gendered language in the name of our clinic. Like most clinics in Canada, it includes the word "women." We asked students for ideas and brought forward suggestions to the clinic administration for consideration of a name change.

Key Guidance Issues

We were surprised by how many different professions were interested in our course, far beyond nursing, medicine, social work and pharmacy. Ten key guidance issues for future iterations of this course emerged:

(1) "If you build it, they will come": there is an appetite for this type of learning if it is available.
(2) Students enjoyed learning about the other professions' content, e.g. social workers liked learning about the clinical details, nursing and medical students appreciated the social work lens, reinforcing the value of the IPHE approach.
(3) "Do not underestimate the power of the basics." Across professions there was a startling lack of knowledge about contraception. This course filled an important gap.
(4) Small group discussions allowed frankness and open disclosure.
(5) Synchronous learning allowed for educational conversation.
(6) We found larger "small" groups, with 10 students each and two facilitators, rather than five students and one facilitator, was more conducive to stimulating conversation and also provided a buffer should one of the facilitators be sick or otherwise unavailable.
(7) Feedback altered how we offered the next iteration of the course. We will continue to seek feedback and adjust accordingly.
(8) It is critical to discuss colonialism and racism with respect to reproductive oppression when discussing reproductive rights and health.
(9) The facilitator team comprised both professors and clinicians, which we found to be mutually supportive and provided us with our own learning.
(10) Holding facilitator meetings between the sessions allowed reflection and adaptation in real time, rather than leaving these discussions to a debrief at the very end of the course.

Conclusion

As abortion has been decriminalized in Canada for more than three decades, it is long past time for dedicated content on abortion, contraception, and reproductive justice to be included in health professional education programs. By situating our course in the context of interprofessional education, we aimed to enhance participant knowledge of not only abortion care and their role but how to support patients as part of a community of health care providers. Too often our professions exist in silos despite the fact that both evidence and lived experience tell us that our patients lives do not. With students from several different programs and a facilitation team representing different professions and academic disciplines, the course created an environment where multiple perspectives and areas of work are valued and shared equally. This course allowed students an opportunity to learn the clinical content and history with their peers through a framework of social and structural determinants of health. Both didactic content and small group discussions allow participants to learn new information and to process, discuss, and apply that information in real time. We will continue to seek and respond to feedback from students and facilitators, allowing the course to adapt over time to reflect best practices and socio-political change.

Declaration of Competing Interest

Authors MP, DL, LY, AF and KT are employees of a publicly funded abortion clinic.

Acknowledgments

The authors would like to acknowledge the support of Dr. Kelly Lackie and Dr. Ruth Martin-Misener in supporting the development of the mini-course.

References

Bonnington, A., Dianat, S., Kerns, J., Hastings, J., Hawkins, M., De Haan, G., & Obedin-Maliver, J. (2020). Society of family planning clinical recommendations: Contraceptive counseling for transgender and gender diverse people who were female sex assigned at birth. *Contraception*, *102*(2), 70–82. doi:10.1016/j.contraception.2020.04.001.

Canada (2017). Age of consent to sexual activity. Retrieved from: https://www.justice.gc.ca/eng/rp-pr/other-autre/clp/faq.html

Canadian Institutes of Health Information (2017). Induced abortions in Canada 2017. Retrieved from: https://www.cihi.ca/sites/default/files/document/induced-abortion-2017-en-web.xlsx

Canadian Interprofessional Health Collaborative (2010). A national interprofessional competency framework. Retrieved from: http://ipcontherun.ca/wp-content/uploads/2014/06/National-Framework.pdf

Costescu, D, Guilbert, E, Bernardin, J, Black, A, Dunn, S, Fitzsimmons, B, & Wiebe, E (2016). Medical abortion. *Journal of Obstetrics and Gynaecology Canada*, *38*(4), 366–389. doi:10.1016/j.jogc.2016.01.002.

Costescu, D, & Guilbert, É (2018). No. 360-induced abortion: Surgical abortion and second trimester medical methods. *Journal of Obstetrics and Gynaecology Canada*, *40*(6), 750–783. doi:10.1016/j.jogc.2017.12.010.

Dobson (Litigation guardian of) v Dobson, (1999) 2 SCR 753. Retrieved from https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1716/index.do.

Dunsmuir, M. (1998). Abortion: Constitutional and Legal Developments. Government of Canada. Retrieved from: https://publications.gc.ca/Collection-R/LoPBdP/CIR/8910-e.htm#C.%20The%201969.

Grant, T. (2020). There's a new form of birth control on the market in Nova Scotia. Here's what you need to know. *CBC News*. Retrieved from https://www.cbc.ca/news/canada/nova-scotia/nexplanon-birth-control-implant-1.5856559.

Health Canada. (2015). Regulatory decision summary: MIFEGYMISO. Retrieved from: http://www.hc-sc.gc.ca/dhp-mps/prodpharma/rds-sdr/drug-med/rds_sdr_mifegymiso_160063-eng.php

Health Canada. (2017) MIFEGYMISO. Health Canada updates prescribing and dispensing information for Mifegymiso. Retrieved from: http://healthycanadians.gc.ca/recall-alert-rappel-avis/hcsc/2017/65034a-eng.php

Hubacher, D., Spector, H., Monteith, C., Chen, P.-L, & Hart, C. (2015). Short-acting and long-acting reversible contraceptive methods: Comparing effectiveness using a partially randomized patient preference trial. *Contraception (Stoneham)*, *92*(4), 382. doi:10.1016/j.contraception.2015.06.115.

LaRoche, K. J., & Foster, A. M. (2018). Exploring Canadian women's multiple abortion experiences: Implications for reducing stigma and improving patient-centered care. *Women's Health Issues*, *28*(4), 327–332. doi:10.1016/j.whi.2018.04.002.

Levenson, J (2017). Trauma-informed social work practice. *Social Work (New York)*, *62*(2), 105–113. doi:10.1093/sw/swx001.

Norman, W. V., Guilbert, E. R., Okpaleke, C., Hayden, A. S., Steven Lichtenberg, E., Paul, M., White, K. O., & Jones, H. E. (2016). Abortion health services in Canada: Results of a 2012 national survey. *Canadian Family Physician Medecin de Famille Canadien*, *62*(4), e209–e217.

Nova Scotia (2018). Child and Family Services Act. Retrieved from: https://nslegislature.ca/sites/default/files/legc/statutes/children%20and%20family%20services.pdf.

Nova Scotia. (2021). Family Pharmacare. Retrieved from: https://novascotia.ca/dhw/pharmacare/family-pharmacare.asp.

Paynter, M., Norman, W. V., & Martin-Misener, R (2019). Nurses are key members of the abortion care team: Why aren't schools of nursing teaching abortion care? *Witness: The Canadian Journal of Critical Nursing Discourse*, *1*(2), 17–29. doi:10.25071/2291-5796.30.

Riddle, J. (1991). Oral contraceptives and early-term abortifacients during classical antiquity and the middle ages. *Past & Present*, (132), 3–32.

Roberts, D. (1997). *Killing the black body: Race, reproduction, and the meaning of liberty* (1st ed.). New York: Pantheon Books.

R. v. Morgentaler 1988 1 SCR 30. Retrieved from: https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do.

R v Sullivan, 1991 1 S.C.R. 489. https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/733/index.do.

Shaw, J. (2019). Abortion in Canada as a social justice issue in contemporary Canada. *Critical Social Work*, *14*(2), 2–17. doi:10.22329/csw.v14i2.5878.

Simpson, L. (2018). Violent victimization of lesbians, gays and bisexuals in Canada. *Statistics Canada*. Retrieved from https://www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54923-eng.htm.

Smith, E. (2020). New abortion course for health students to be offered this year. *CBC News*. Retrieved from https://www.cbc.ca/news/canada/nova-scotia/abortion-education-martha-paynter-dalhousie-university-nursing-training-1.5699583.

Solar, O & Irwin, A. A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice). World Health Organization. 2010 Retrieved from: https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

Stote, K (2017). Birthright denied: The sterilization of indigenous women. *Herizons (Winnipeg)*, *31*(2), 13–16.

Tremblay v Daigle 1989 2 S.C.R. 530. https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/515/index.do.