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ABSTRACT

Purpose: To determine women's preferences for the location of early abortion services.

Description: Between July and December 2006, 209 women at a university-based primary care center and a freestanding abortion clinic completed a verbally administered questionnaire in which they were asked their preference for the location of early abortion services.

Assessment: Sixty women seeking primary care services at the university-based clinic and 149 women seeking first-trimester abortion services at an abortion clinic completed the questionnaire. Sixty-seven percent (67%) of women surveyed at the university-based primary care facility and 69% at the abortion clinic indicated a preference for abortion services from their regular health care provider. A statistically significant association ($p=0.002$) was found between comfort speaking with a regular health care provider about pregnancy prevention and preference for the provision of abortion services from a regular health care provider.

Conclusions: Women may feel more comfortable undergoing an early abortion procedure with a provider with whom they have an established relationship. The integration of early abortion services into primary care practice may increase continuity of care among women seeking an abortion.

Keywords: abortion, induced; primary care; continuity of care; reproductive age

Purpose

Nearly half of unintended pregnancies in the United States are terminated, resulting in 1.2 million induced abortions annually. Most of these abortions are performed in the first trimester. Additionally, the majority of these abortions are provided in freestanding abortion clinics by physicians who deliver specialized services, generally without much knowledge of the woman's medical history. (1) The delivery of abortion services in a specialized, unfamiliar clinic could be perceived as a disadvantage as it relates to patient care because, to the extent that women have a medical care home, it reflects a disruption in the relationship between a woman and her regular primary care provider. Moreover, this disruption in care comes at a time when a woman may feel vulnerable and might benefit from seeing a provider with whom she has an established relationship.

Early abortion services, both surgical and medication, have been shown to be both safe and acceptable among women and providers when offered in a primary care setting. Primary care providers have shown interest in incorporating early abortion services into their practice, both medically and surgically. Wu et. al. found that, after a brief educational lecture on medication and surgical abortion, family medicine residents in ten New Jersey family medicine programs had an increased interest in abortion training, particularly medication abortion training. (2) Schwarz et. al. also found that the provision of medication abortion services was of interest to future internists in six internal medicine, two family practice and three gynecology postgraduate

training programs in the San Francisco Bay Area. (3) Despite primary care provider interest in providing early abortion services, a recent study by Finer et. al, found that only a small percentage of the total number of medication abortions in the United States are provided by family physicians (11%). (4) While primary care providers have been slow to introduce early abortion options into their practice, recent studies have indicated that women may be interested in receiving early abortion services from their primary care provider. Prine et. al found that women in New York who had a medication abortion in a family medicine practice, many with their regular primary care physician, both accepted and were very satisfied with the procedure. In the Prine study, outcomes among women who received a medication abortion at the family medicine clinic were comparable to those among women who received a medication abortion at a specialty reproductive health clinic. (5)

An important gap in the abortion literature is the paucity of research on women's preferences for the location of early abortion services. To our knowledge, there are only three studies that have included an examination of women's preferences for the location of early abortion services. In a recent study, Shochet and Trussell found that, among 205 women seeking abortion services at three Planned Parenthood clinics in Iowa, 65% indicated that they would prefer not to see their primary care provider for abortion services while 20% reported the opposite preference. (6) A second study examined the abortion location preferences of 449 women at three family medicine clinics in the Bronx, New York. Of 231 respondents who indicated that they would consider an abortion if necessary, 80% reported feeling positive about abortion being offered by their family physician. Among these women, approximately 67% indicated a preference to have an abortion with their family physician as opposed to a private abortion clinic. (7) A third study, which took place at abortion clinics in New York and Chicago

found that, among women who were about to have a first trimester abortion, the majority indicated a preference for having an abortion with their primary care provider. This study included a partial analysis of the data presented in the current study but did not go beyond the abortion clinic to compare preferences among women within different clinical settings. (8) The current study seeks to compare the abortion location preferences among women at two types of clinical settings, a primary care clinic and a freestanding abortion clinic. Comparison of abortion location preferences among women in two types of clinical settings allows us to gain a broader understanding of women's preferences for the location of abortion services. It is hoped that results of this study can help inform future discussions about the incorporation of early abortion services into primary care settings.

Description

An anonymous questionnaire created by Rubin et. al. (7) was verbally administered by a research assistant to a convenience sample of 209 consenting women ages 18 to 45 between July 2006 and December 2006. Questionnaires were administered at a university-based primary care clinic and a high-volume freestanding abortion clinic in Chicago. The freestanding abortion clinic provides confidential abortion services up to 24 weeks gestation, but the survey was administered on days in which first trimester surgical services were primarily offered. All providers at the freestanding clinic are board certified Obstetricians-Gynecologists (OB/GYNs) who do not have a practice outside the abortion clinic. The university-based clinic provides primary care services to both a community and university student population. This clinic offers contraception and options counseling but, at the time of these interviews, did not offer abortion services.

Women who met the inclusion criteria were invited to complete the questionnaire. Inclusion criteria at the university-based primary care clinic included females aged 18-45 seeking primary care services who could speak and understand English. Inclusion criteria at the freestanding abortion clinic included females aged 18-45 who had identified a "regular" source of care, were waiting to undergo a first trimester abortion procedure at the freestanding clinic, and could speak and understand English.

After determining eligibility, participants were taken to a private area of each clinic to complete the questionnaire which consisted of 29 open and close-ended questions and took approximately 15-20 minutes to complete. Close-ended questions included a combination of dichotomous and multiple choice questions as well as those which were scored on a five-point Likert scale. Questions included women's preferences for the location of abortion services ("Some women have abortions at an abortion clinic. Some women have abortions at their regular doctor's office. If you had both options, which place would you choose?"), current primary care provider type, length of time participant has been seeing current primary care provider ("How many months or years have you been going to your regular medical office or clinic?"), knowledge of medication abortion and thoughts on whether or not their primary care physician should provide this option ("Have you ever heard of medication abortion?", "Do you think your regular clinic should or should not offer medication abortions for their patients?"), and participants' comfort speaking with their regular provider about pregnancy prevention and contraception ("A lot of women have questions about preventing pregnancy and contraception. How comfortable are you talking with your doctor about these types of questions?"). For the purposes of this study, regular primary care provider refers to the provider whom the participant identified as the person who performs her annual pap smear. Health and demographic

information was also collected which included age, educational attainment, health insurance source, and prior history of induced abortion.

Statistical analyses were performed using SPSS 15.0 (Chicago, IL). Chi square tests were used to evaluate the associations between demographic characteristics, prior history of induced abortion, comfort speaking with their regular provider about contraception and pregnancy prevention, and preference for the location of abortion services. Statistical significance was considered to be a p value of less than 0.05. Qualitative data obtained in the open-ended portion of the questionnaire were reviewed by two of the three authors for common themes. The study protocol and survey instrument were approved by the Institutional Review Board at the University of Illinois at Chicago.

Assessment

A total of 212 women, 149 at the freestanding abortion clinic and 63 at the university-based primary care center, agreed to participate in the study. Three women at the university-based primary care clinic were called for their appointment before completing the questionnaire and thus were excluded from the analysis, resulting in a total sample size of 209. Of the 60 women who completed the questionnaire at the university-based clinic, 18 women indicated they would never have an abortion and were therefore excluded.

The mean age of participants at the university-based primary care center and freestanding abortion clinic was 26.4 and 28.5, respectively. Participants at the university-based primary care center reported higher levels of educational attainment than participants at the freestanding abortion clinic. Furthermore, participants at the university-based clinic were more likely to have health insurance categorized as “other” (60%). Because the survey was administered at a university-based clinic that also serves as the student health clinic, the likely source of this

insurance was a university-based plan. Main sources of health insurance for women at the freestanding abortion clinic were employer-based plans (59.7%) and Medicaid (14.8%) (Table 1).

Relatively few women at the university-based clinic indicated a history of elective abortion, while almost half of the women at the freestanding abortion clinic indicated at least one prior abortion. The average number of prior abortions obtained in this population was 1.8 ± 1.2.

Women at both sites indicated a strong preference for undergoing an abortion with their regular healthcare provider as opposed to a freestanding clinic. Approximately 67% and 69% of participants at the university-based primary care center and freestanding abortion clinic, respectively, indicated a preference for undergoing a medication or surgical abortion with a regular health care provider. When women who answered "don't know" were excluded, there was no significant difference between study sites with respect to women's preference for the location of abortion ($p = 0.068$) (Table 2).

Participants at the abortion clinic who indicated feeling very comfortable speaking to their regular health care provider about pregnancy prevention were significantly ($p=0.002$) more likely to indicate a preference for abortion with their regular provider (77.6%) than those who reported feeling less comfortable speaking with their regular provider about pregnancy prevention (51.3%). At the university-based primary care center there was no relationship between comfort speaking to one's regular provider and preference for abortion with the woman's regular provider. Importantly, regardless of comfort level in speaking with their regular health care provider about pregnancy prevention, the majority of women at both sites preferred to see their regular health care provider for an abortion.

In the open-ended response section of the questionnaire, women at both sites who preferred seeing their regular provider for abortion explained that they had developed a sense of trust and familiarity with their regular health care provider and, as a result, they would feel more comfortable receiving an abortion from him/her (n=88). Women who preferred to see their regular provider for abortion also cited the desire for convenience (n=11) and less contact with protestors (n=3).

Among women who preferred to have an abortion at a freestanding clinic, 13 indicated in the open-ended part of the questionnaire, that they would feel more comfortable having an abortion at a clinic that performs abortions more frequently and, thus, may have more experience with the procedure. Among women who indicated a preference for abortion at a freestanding clinic, 31 stated that they would prefer this option because they would like to remain anonymous. Three women stated they would not want the abortion to be listed on their regular provider's medical records. Furthermore, two women stated they would prefer to have an abortion at a freestanding clinic because the provider would be less judgmental than their regular provider.

Conclusions

This study examines women's preferences for the location of abortion services at two different clinical sites with women in different circumstances; women at both sites indicated a preference for seeing their regular health care provider for an abortion. While the majority of women waiting to have an early abortion at the freestanding clinic indicated a preference for seeing their regular health care provider for an abortion, many women also expressed concern about their regular provider judging them for their decision to have an abortion. If a provider does not take the opportunity to speak with female patients about abortion and contraception prior to the time at which she needs to utilize these services, she may not feel comfortable

speaking with the provider about these services when they become necessary. It is not uncommon for physicians to have moral objections to the provision of abortion services or to disclose these objections to their patients. In a 2007 mail survey of 2,000 United States physicians from a wide spectrum of specialties, Curlin et. al. found that 63% of physician respondents felt it was ethically permissible to tell their patients of their moral objections. (9) Women may perceive this judgment on the part of their regular physician and, as a result, prefer to seek abortion services at freestanding clinics. Perception of judgment from the regular health care provider may also prevent women from disclosing a previous abortion, causing a disruption in continuity of care. Knowledge of a woman's prior abortion may increase the quality of care a primary care physician can provide by increasing his/her ability to counsel the patient on an appropriate contraceptive method.

Taking the opportunity to speak with a patient about her reproductive options before she becomes pregnant may facilitate a nonjudgmental forum for discussion of these topics. As we found in our study, women who felt more comfortable speaking with their primary care provider about pregnancy prevention were significantly more likely to prefer to see their primary care provider for early abortion services. However, integrating abortion services into primary care settings will require primary care providers to have ample opportunity to learn the procedure during their medical residency program. A study reporting on obstetrician-gynecologists who received abortion training found that stigma and ideological contention surrounding abortion is a significant barrier to providing the service after residency graduation. (10) Regarding family physicians, according to the 2003 Society of Teachers of Family Medicine Group on Abortion Training and Access, only 11 of 480 family medicine programs at the time of the survey offered abortion training as part of their residency programs. (11) Nonetheless, integration of abortion

training programs into family medicine residency programs has been shown to be successful. Paul et. al. found the integration of abortion training into three family medicine training programs in San Francisco to be both safe and effective with complication rates comparable to those of more experienced providers (1.0%). Furthermore, resident satisfaction with abortion training was positive and increased their interest in future abortion provision. Few complications were reported and, overall, women were highly satisfied with the services they received. (12)

The current study has several limitations. Because the study used convenience samples, results are not generalizable to the larger population of women; similar studies with diverse populations in diverse cities, states and regions should be undertaken. Another limitation is the small sample size at the university-based clinic which may have led to insufficient power to detect differences between various sub-groups of women.

The results of this study show that women seeking health care in two types of clinical settings both prefer to see their primary care provider for early abortion services. Given the preference of some women to undergo an abortion with their regular health care provider, integrating abortion services into a primary care setting may be a positive step towards ensuring patient satisfaction and positive health outcomes through continuity of care.

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