



Abortion clinic patients' opinions about obtaining abortions from general women's health care providers

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ABSTRACT

Objective: Most U.S. women obtain abortions at specialty clinics. This qualitative study explores abortion clinic patients' opinions about receiving abortions from general women's health care providers.

Methods: We conducted 20 h-long, semi-structured interviews with diverse women who had abortions in the U.S. Heartland. Each described her usual health care provider and how she accessed abortion care. We used qualitative analytic methods to organize and interpret the data.

Results: Despite having a general provider, most women sought clinic abortions. Some women offered reasons for preferring specialty care and others for preferring abortion from their general provider. Most women assumed their general provider did not "do abortion" and many believed those providers were opposed to abortion. Women who had delivered a baby were concerned with their image in their general provider's eyes. Two women were denied care by their general providers.

Conclusion: Women's preferences for abortion care centered on privacy, cost, empathy, ability to control their image, and desire for safe quality care. Two women who sought abortions through their general providers experienced negative repercussions.

Practice implications: General providers should proactively make patients aware of their positions on abortion and if supportive indicate that they can provide that care and/or a referral.

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1. Introduction

Abortion is one of the most common health care needs for women of reproductive age. Approximately half of all pregnancies in the United States (U.S.) are unintended and 40 percent of those pregnancies end in abortion [1]. Consequently, by age 45, 1 in 3 women in the U.S. will have an abortion [2] resulting in approximately 1.2 million abortions annually. Despite the high demand for abortion services, that care is provided in a limited number of facilities across the country and the number of providers continues to decline. In 2005, only 1787 facilities in the country provided abortion care [3]. By comparison there are over 20,000 practicing obstetrician–gynecologists [4] to perform approximately the same number of Cesarean deliveries (1.3 million) [5] although that procedure is significantly more complicated to perform. Within the small number of facilities that offer abortion care, those that are identified as "abortion

clinics" (381 facilities), in which over half of patient visits are for abortion services, provided 70 percent of all the abortions performed in the United States in 2005 [3]. This specialization of services is the result of three decades of contributing factors including the development of the women's health movement which pushed for women-controlled spaces for abortion care [6,7], the failure of mainstream medicine to routinely incorporate abortion into medical training [8,9], the rise of violence against abortion providers [10], and the high number of regulations that limit where and how abortion services can be provided [11].

As a result of the specialization of abortion services, most women now receive abortion care outside of the context of their general health care, yet the separation of abortion from other health care is not broadly recognized by many women. We do note that for some women the abortion clinic may be their only source of health care but is not usually a place where they can receive general women's health care, thus in the context of this paper we do not consider the abortion clinic a general woman's health care provider.

Although women may access abortions elsewhere, some women may need assistance to locate a qualified provider of abortion services and some women may desire a sympathetic relationship with their regular provider following their abortion experience. Women needing abortion care for medical indications

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in a desired pregnancy may need a direct referral to a provider given the complexity of their medical situation [12]. Women living in more conservative locations, however, may be the least likely to find a sympathetic provider for an abortion referral or for nonjudgmental care following an abortion.

The separation of abortion from general women's health care can create complicated disclosure situations for women. Women desiring an abortion referral do not know how their provider will react to this request. Likewise, since pregnancy history including abortion is often elicited on intake forms, women must navigate disclosing their abortions to a provider who may or may not be supportive of that decision. Surveys of physician attitudes about controversial health care reveal that such disclosure is risky. In a survey by Curlin and colleagues, 63 percent of physicians believed that it is ethically permissible to tell patients about their personal objections to a particular health care service and 29 percent did not think a physician had an obligation to make a referral for the objected service or were undecided [13]. And among physicians who identify as religious only 56 percent felt that physicians are obligated to disclose all possible health care options [13]. A recent systematic review documents the extent to which refusals are a violation of established standards of care [14] and anecdotal evidence suggests negative consequences for women [15–18].

Little is known about how women experience physicians' negative attitudes about abortion, referral refusals, or denials of care. What research there is suggests women prefer specialty abortion clinics in order to avoid those experiences [19]. This paper uses data from qualitative interviews with women obtaining abortions from specialized abortion facilities in the U.S. Heartland to begin to understand abortion care in relationship to providers of general women's health care. It offers insight into how women decide whether or not to seek abortion care, referral or support from their general women's health care provider, and what they might want from their general health care provider.

This paper is not proposing the hypothesis or drawing the conclusion that abortion care is better provided in either a specialty or a general health care practice. The high safety record of abortions in the U.S. [20,21] is evidence of the clinical proficiency of the current specialty care delivery system. At the same time, evidence also suggests that early abortion is safely performed by primary care providers including family physicians, internists, nurse practitioners, nurse midwives and physician assistants [22–32]. Additionally, many obstetrician–gynecologists perform abortion procedures only periodically for women with medical or fetal indications [3,33] suggesting that high volume is not necessary to maintain surgical skills for some providers. While the quality of abortion care in the U.S. is high, access to care is inconsistent and favors women with higher incomes and who live in densely populated areas on the East and West Coasts [3]. Given longstanding recommendations in the reproductive health field to expand abortion services in more health care settings as a way of improving access [34,35], we hope to shed light on what women think about disclosing their need for abortion to their general women's health provider and accessing abortion in those settings.

2. Methods

Between June 2006 and August 2007, we conducted 20 interviews with women who obtained abortions from three clinics in two states in the U.S. Heartland. Interviews focused on women's experiences with abortion care and abortion regulation. We defined the Heartland as states between Colorado on the West and Tennessee on the East and between South Dakota to the North and Texas to the South. As there are very few providers in the states where we conducted recruitment, we have decided not to reveal

state names in our study to protect our participants and recruitment sites from a loss of confidentiality and privacy. Women were recruited from facilities defined as abortion clinics, meaning that over half of their patient visits are for abortions. The Institutional Review Board at the University of California, San Francisco, approved this study.

We used purposeful sampling to recruit participants for our study. To be eligible for the study women had to (a) speak English, (b) be at least 18 years of age, and (c) have had an abortion or be planning for an abortion. Most women in the sample were introduced to the study during their abortion consultation appointment by a health worker, nurse or clinician; others saw flyers in the clinic and requested to meet one of the authors. After our initial recruitment phase, we changed our recruitment procedure slightly to increase the diversity of our sample. Since our initial recruitment sample was predominantly white and young, we directed clinic staff to focus their efforts on recruiting women who were older and non-white. Although young white women comprise the majority of abortion patients, women of color have higher rates of abortion [36] and differential access to general health care [37]. Clinic staff used intake forms to determine patient age and race or ethnicity. However, we did not have access to these forms and did not conduct any chart reviews. We evaluated interested patients for eligibility and interest in the study. Of approximately 33 introductions, 30 women made interview appointments or gave contact information and 20 completed their interviews (13 from one state and 7 from the other). We stopped recruiting when we had obtained a range of experiences and opinions.

The authors conducted all 20 interviews in-person. Women received a \$30.00 compensation for their time. In the following paper we will examine patient answers to the first two sections of the interview guide which explored how women came to find their abortion provider and by whom they thought abortion should be provided. Their answers were in response to several prompted questions: Do you have a regular place you get health care? What are your preferences for regular/normal gynecological care (including gender and age of doctor, type of setting)? How does abortion as a service fit into your idea of normal gynecological care? How is it the same or different than other gynecological services? If your regular provider offered abortion would you have gone there? What would an abortion at your regular place be like?

Because the interview was semi-structured, the questions were not asked of all respondents in identical ways. If a woman answered a question that led her to an issue of relevance in another part of the interview guide, the interviewer did not return to ensure that all of the above listed questions were answered. This interview-based approach to qualitative methods is designed to elicit women's narratives about their experiences. The findings are not meant to be generalizable to the whole population of women obtaining abortions. Of relevance to this paper is the range of experiences rather than an average or typical experience.

The patient interviews were transcribed and the transcriptions were compared to audio recordings to check for accuracy. All subjects were assigned pseudonyms. We used the software program Atlas Ti to code and memo our interviews. Using grounded theory analytical techniques described by Kathy Charmaz, in *Constructing Grounded Theory*, initial line-by-line coding led to the development of axial codes based on important subjects discovered in the text [38]. To investigate women's thoughts about providers, we searched our axial codes for content related to health care providers and accessing care. We also searched our data using our semi-structured interview guide to develop a matrix that allowed us to compare answers to certain questions across participants. This also allowed us to explore the opinions of each participant across questions. Finally, we searched

our transcripts for key terms such as “regular provider,” “regular doctor,” and “abortion provider” to identify any additional references to the behavior and relationships we were investigating.

3. Findings

3.1. Participant characteristics

Participant demographic characteristics are included in Table 1 of this paper. Nine women identified as white, seven as African American, three as Native American (one mixed Polynesian), and one as Hispanic. Women ranged in age from 18 to 43. Women in the sample had very diverse histories with pregnancy and the health care system. Fifteen of the women had at least one previous pregnancy prior to their most recent pregnancy. Of these women, six had experienced four or more pregnancies. Twelve of the women were raising children. Six had at least one previous abortion and two had children who were being cared for by another adult. Additional information on these women's opinions about abortion policies can be found elsewhere [39].

Fifteen of the women had what they considered a general women's health care provider of women's health care: 10 of these had a general provider who was an obstetrician/gynecologist (ob/gyn) or a family practice physician; the remaining women went to health clinics for regular care (not shown). Of the 13 women who had previously given birth, four had given birth under the care of their current physician. Ten out of the 15 women in our sample who had a general provider, did not ask their general provider if he/she provided abortion. These patients sought information about clinics from the phone book or the Internet, rather than obtaining a referral from another doctor or medical provider.

Using qualitative analytic techniques we identified two dominant themes in women's narratives: (1) preferences for the integration or for the separation of the abortion services and (2) the role that disclosure plays in women's preferences and experiences. Women could express overlapping and even contradictory opinions in telling their stories.

3.2. Preferences for integration or for separation of the abortion services

When asked if they would have preferred that their general provider offered abortion, four women spoke specifically about how that would have increased their comfort although “comfort” means different things to different women including more familiarity, greater convenience and cheaper services.

Although Jackie believes that doctors' decision to perform abortions is “their choice,” if her doctor did perform them she “would probably go to her because I would feel more comfortable.” Even those without a regular source of care could conceptualize this difference. Tricia who did not have a regular physician at the time of the interview, noted her preference for receiving an abortion from someone with whom she had an ongoing relationship because, as she notes, “[I] probably would feel a lot more comfortable.” In these cases, comfort seems to represent a feeling of familiarity.

Jennifer did not consider her local provider in her conservative community for an abortion because it was part of a Catholic healthcare system. When asked to consider what it would be like if her regular provider did provide abortions she said:

[Seeing my regular provider] wouldn't make me feel like I have to hide it. You know, that I have to go somewhere else to do it. I just – it's ridiculous, you know? I mean, it's just another stress that you have to do. You have to go and travel to find a place to do it. Where it could have been easily done close to home, get home, be safe, be comfortable. But, you know, now he has to drive three hours with me passed out in the seat.

In this case, comfort seems to be associated with convenience and a reduced need for travel.

Joy provided yet another perspective on the role of cost, anticipating that the abortion would be cheaper at her general provider. When asked if she would have had the abortion at her regular clinic if they offered it, she answered an unequivocal “yes.” Her reasoning began with the assumption that since the place she went for her regular care was a “free clinic” the abortion would also have been free (there is no Medicaid funding for abortion in the

Table 1
Patient characteristics.

Pseudonym	Demographic information				Pregnancy history		Regular provider experience	
	Age	Ethnicity	Educational background	Income	# of children	# of abortions	Has a regular provider	Previous delivery w/regular provider
Aisha	21	N. Amer. ^a	Some Technical	0	1	2	Unknown	Yes
Amanda	25	White	Some College	1500	4	1	Yes	Yes
Angela	20	Black	Some College	0	1	2	Yes	No
Beth	39	White	Some college	0	2	1	Yes	No
Cassie	25	White	College Graduate	2666	0	1	No	No
Cheryl	43	White	G.E.D	2300	2	1	Yes	No
Deb	41	White	Graduate Student	>2500	1	1	Yes	No
Jackie	Unknown ^b	Black	Some College	Unknown ^b	3	2	Yes	No
Jennifer	27	White	College Graduate	1500	0	1	Yes	No
Jessie	18	Poly/N.Amer. ^a	High School	0	0	1	Yes	No
Jordan	25	Black	High School	1200	1	1	Yes	No
Joy	28	N. Amer. ^a	College Graduate	1500	0	3	Yes	No
Lisa	23	White	Some College	0	2	2	Yes	Yes
Lyndsay	18	White	High School	<2500	0	1	No	No
Makayla	27	Black	Some Graduate	1800	2	1	Yes	Yes
Maricel	24	Hispanic	Some High School	1500	1	2	No	No
Sonja	25	Black	College Graduate	1000	0	2	No	No
Tanya	25	Black	College Graduate	2000	4	1	Yes	Yes
Tricia	19	White	Some College	500	0	1	Yes	No
Vanessa	23	Black	College Graduate	1500	0	1	Yes	No

^a N. Amer., native American; poly, Polynesian.

^b Survey incomplete.

state where Joy lives). What matters to Joy is “how much it would cost” but if costs were the same she notes she would prefer her regular clinic because it is more “comfortable.”

Several women in our sample did not indicate a preference for whether abortion was provided in the context of their regular source of care. As Aisha explained, she would go “wherever” it was offered. For those individuals who never considered whether their usual source of care should offer abortions, we explored whether they thought abortion should be offered as part of regular women’s health. Several women noted that they saw abortion as “different.” As Jordan explains: “I don’t know, I can’t put it into words. It just seems, I don’t know, it just seem different.” Thus, almost as a tautology, abortion is different and therefore would not be provided in any way other than as a separate service.

For Vanessa, the difference had to do with her perception of the medical complexity of abortion and the limitations of the small clinic where her doctor provided medicine. Stating that abortion is a form of medical specialty and that she preferred a specialist perform her abortion, Beth delineated what others hinted at:

I just wanted some place that that’s all they did, you know. I know [the clinic] do[es] other things too but I mean, just, I believe in specialists. You know, I believe if you have a skin problem you go to a dermatologist, if you have a heart problem you go to a cardiologist. You know, it’s just smarter.

But that specialization is not just about the clinical care; it is also about the specialness of the providers who perform abortions. As Cassie explains, the doctors who do abortions may feel compelled by some internal drivers that make them advocates for the women who need abortions:

You know if a doctor is specializing in abortion and, and is doing abortions, he obviously has to, it’s a different breed of doctor, I would say. Because, you know, to me it just seems that he’s providing a service that a lot of people think shouldn’t be a service.

3.3. The role of disclosure

Four of the women did not ask their regular provider for an abortion because they assumed that he/she was opposed to abortion. Each of these women had delivered a child with their general provider and feared that the relationship would change if knowledge of their abortion came to light. Tanya had a regular doctor who delivered all four of her children. When asked whether she considered going to him for the abortion she said: “No, I don’t think he does abortions. . . He probably would have talked me out of it more than likely. Yeah, he would.”

Makayla had a similar expectation of her general provider’s reaction but explains that for her the fear is also tied up in failing to comply with the physician’s recommendations for preventing the pregnancy.

He may not have wanted me to do it. . . We had kind of developed a real close relationship and he probably would’ve fussed at me because he tried to get me to get other methods of birth control.

When prompted further to discuss returning to her doctor’s office for care after the abortion, Makayla continues: “But then I was thinking if I go to my OB [after the abortion] then I should let him know that I’ve had one. But then he might be upset with me.”

Amanda’s story highlights how important preserving the doctor/patient relationship can be to some women. Amanda was a 25-year-old mother of four children. With her first two pregnancies and deliveries she had horrible healthcare experiences. Her fourth pregnancy was the result of a rape by a family

friend. Her current doctor provided her care after the ordeal, encouraged her to keep the pregnancy, and supported her through her delivery. With her fifth pregnancy, Amanda reluctantly decided to have an abortion without consulting her general provider.

They’re like family. So for me to go to him and ask him or talk to him about anything like this, I think that he would frown upon it. He has three kids of his own and they’re around the same ages of my kids and I just don’t think that he would think very highly of it. . .

For women who had close relationships with their doctors, concealing their abortion allowed them to avoid disrupting the relationships, protected the doctor from having to perform an unseemly procedure, and ensured positive interactions in the future. As Lisa summarized:

I don’t think that I would feel comfortable going to my OB-GYN for an abortion, knowing that’s the same man that delivered my children. For me, in my mind, I would have to have the two things completely separate, not because of him, but just because of the thought of me asking him to be that way. . . Even if he never showed any sign, I would, from that day on, be a lot more leery about how I was around him and the things that I would say. And I mean, this is the person that follows you through your pregnancy.

Angela, a mother of a young son, had a friendship relationship with her doctor outside of her medical relationship with him. The existence of an external relationship made it hard for her to even consider telling him about her need for an abortion:

I’ve known him personally outside of a doctor. Like he – his daughter was part of my [basketball] team. They like – the team that I played for, it was expensive and he paid for it. And like they paid for my road trips. And they treated me like I was family. So him being my physician and when I go out there I see him all of the time, I didn’t want to go out there and deal with all of that.

Only three of the women in our sample had discussed or requested an abortion from their regular provider. Each had a different experience, only one of which was positive: Vanessa received a referral for her abortion. For the other two women who discussed abortion with their general provider, the repercussions of disclosure were significantly negative. In each case, disclosure was prompted by an unexpected need for abortion services from their regular provider. Deb was pregnant with a desired pregnancy and seeking prenatal care when her regular physician recommended that she have an amniocentesis because she was over 35 years old. They had not discussed the possibility of abortion prior to the test and when the test came back positive for Down Syndrome, Deb was surprised that her doctor had a policy of neither discussing nor providing the abortion procedure. “He’s been my doctor for 15 years. I had no idea he was – his beliefs were.” After receiving her test results, instead of counseling her about her options, Deb’s doctor brought in experts to talk about raising a child with Down Syndrome. When she made it clear she wanted an abortion, her doctor asked another physician in the office to give her abortion referrals. Afterward, Deb felt a deep sense of betrayal.

This – the – that’s been almost as hard as losing the baby is losing my OBGYN because I really, really, liked him. I was very comfortable with him. And I was – I mean when I found out I was pregnant I, you know, told him I loved him and gave him a

hug. I was just so excited. And so I'm kind of lost. I, I feel betrayed by him that, that he didn't take care of me.

Cheryl's obstetrician/gynecologist diagnosed her with both a pregnancy and a mass on her uterus. Because of her age (43) and the seriousness of her medical condition, Cheryl elected to have an abortion. When the closest abortion provider was unable to do an outpatient abortion (due to the mass), her Ob/Gyn refused to remove the growing mass because the surgery would endanger the pregnancy.

[H]e was more concerned about the fetus than he was my own life. And I'd already told him up front that under no circumstances would I give birth to this baby, none whatsoever. And, he just said, like it was a sin what I was doing.

The medical refusal left Cheryl and her husband with few options. More than a month after her diagnosis, Cheryl finally found an abortion provider in another state who could provide her care. In the end, she needed a hysterectomy because the mass had grown significantly during the delay in her care. Cheryl's experience demonstrates the vulnerability patients have when they are dependent on an existing provider to offer a timely referral: "And like I say, it was all new to us. We didn't know what to do. We were really relying on one doctor's word."

For Cheryl the consequences of the delay were both physical and economic. At the time of the interview, she had already been billed \$11,000 for the hospital care for the mass while she was trying to locate an abortion provider. She was acutely aware of the increasing costs related to her refusal: "I spent probably seventy-five, eighty-five dollars just on medicine for vomiting and pain that I never would have had to have." In the end Cheryl's expenses totaled over \$40,000; Cheryl has no insurance.

4. Discussion and conclusion

4.1. Discussion

In the U.S., abortion is not routinely offered outside of specialty clinics. Despite the safety of care in the general health care setting, only two percent of abortions take place in private physicians' offices [3]. This study of women seeking abortion care in specialized facilities sought to understand their opinions about whether that care should be offered within general women's health care. Women in this study mentioned divergent sentiments. Some women found reasons to support specialty abortion services: privacy, cost, and the qualifications and implied commitment of the provider. Conversely, others noted preferences for the inclusion of abortion among general health services. They believed that if it were offered within their general source of care, obtaining an abortion would be more familiar, convenient and possibly less expensive.

Disclosure played another large role in women's narratives, both fear of disclosure and the consequences of disclosure. Several women in our study specifically avoided disclosing their need for abortion to their general provider because they were certain their provider was against abortion. For women with existing relationships with their providers, particularly those who had delivered a baby with their provider, protecting the ongoing relationship and their own image took precedence over the need for services within the context of regular care. Only one woman in our study successfully obtained a referral for her abortion from her provider. Two women were denied the care they requested resulting in significant emotional, physical, and economic costs.

The major limitation of our study is the small sample size and lack of information about how the 20 women who participated differed from the 13 women who expressed interest but never completed an interview. Consequently the results of this study suggest opportunities to learn more from women regarding their opinions about obtaining care from their general women's health care provider but cannot be generalized to the larger population of all women obtaining abortions in the United States.

4.2. Conclusion

Abortion is a common health care need for women of reproductive age. Its separation as a health care service leads many people, including women in this study, to think of it de facto as specialty care. As health care reform takes effect in the U.S., more individuals will be directed into a system of general health care. However, abortion is unlikely to be part of this reform effort, necessitating the ongoing need for specialty abortion clinics and improved understanding of how abortion care interacts with the rest of women's health care.

Our study offers evidence of the limitations and benefits of our current model of abortion care delivery. Some women suggested that abortion would be more comfortable and less expensive if it was provided as part of their general health care. Other women's fear of judgment and negative effects on the relationship they have with their general providers led them to avoid disclosing their need for an abortion. Finally, and most importantly, two women in our study experienced discrimination and were refused medical care upon disclosure. Their experiences show how vulnerable women are when provider attitudes can take precedence over women's need for abortion services.

In the U.S. context, abortion care is socially and logistically complicated to offer. Negative opinions about abortion among health care providers and/or lack of adequate skills to perform abortion can significantly affect where and how abortion can realistically be provided. Consequently, this paper does not make a normative claim about whether abortion is best provided in the specialty or integrated setting or whether providers should have to offer such care. Rather, it seeks to expose women's interpretations of the current model of care and their preferences for the separation or the integration of abortion services. This paper also explores the experiences of women who are denied care and suggests that such denials can be emotionally, physically and economically costly for women.

4.3. Practice implications

Providers who are supportive of abortion care may need to assume a proactive approach to letting their patients know about their positions on abortions and offering information on referrals before a woman even needs an abortion. Providers who are opposed to abortion should understand the effect those beliefs have on the women for whom they care. Fear of judgment and disapproval no doubt has emotional consequences for the women. Likewise the refusal to appropriately refer for care results in real emotional, physical, and economic costs for women.

Finally, our findings have implications for other stigmatized health needs such as testing for a sexually transmitted infection, securing alcohol or substance use treatment services, dealing with a violent intimate partner, or addressing a mental health concern. In each of these cases, women may desire privacy and specialty clinical settings or they may prefer the familiarity, convenience and lower cost of their general source of care. As with respondents in our study, women may be afraid to disclose their need for these services out of a desire to avoid judgment or to protect their personal image. Women who expect a positive response may

disclose their need only to experience judgment or a denial of services. Future research may want to explore these possibilities.

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Conflict of interest

None declared.

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