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Original Research Article

"We just need to create as many avenues for access as we possibly can": Clinician and administrator attitudes toward telehealth medication abortion in the U.S. South

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ABSTRACT

Objectives: There is currently a gap in literature on the perspectives of sexual and reproductive health providers in the South toward telehealth abortion services. This research seeks to explore these perspectives to understand provider attitudes toward importance and priority of telehealth abortion to contribute to the development of a richer understanding of this in the South.

Study design: This study conducts a secondary analysis of data from the Provider Readiness for Virtual Implementation and Delivery of Medication Abortion Services (PROVIDA) study. We collected qualitative data regarding perspectives of 20 providers toward importance and priority of telehealth abortion during a series of in-depth interviews that took place from June 2021–2022.

Results: We identified four main themes: telehealth abortion is important for patient benefit in mitigating physical, administrative, financial, and privacy-related barriers; telehealth abortion is important for clinic benefit in improving clinic flow and sustainability; the political climate affects personal prioritization of telehealth abortion; and staff hesitance affects clinic prioritization of telehealth abortion.

Conclusions: Our analysis revealed telehealth abortion to be particularly important in mitigating physical barriers for patients and for clinic sustainability. We found the political climate to be the most notable factor influencing personal prioritization of telehealth abortion, with most participants noting it made telehealth abortion less of a priority. Additionally, our analysis found participant perception of staff hesitation to implement telehealth abortion to be the most notable factor affecting clinic prioritization. Future research should utilize these findings to inform studies examining the implementation climate of telehealth abortion in the South.

Implications: Highlighting insights from SRH professionals in restrictive environments, this study emphasizes the potential of telehealth abortion to mitigate the unique barriers to access and provision that abortion seekers and providers face in the U.S. South. This has important implications for motivating implementation in states where abortion is still legal but telehealth abortion is prohibited.

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1. Introduction

A lack of access to abortion services has strong implications for the health and well-being of pregnant individuals and their families [1]. Adverse outcomes include higher odds of experiencing economic distress and an increase in the risk of total maternal mortality in the U.S., exacerbated among vulnerable, marginalized, and disadvantaged communities and placing these populations at high risk of adverse health outcomes [2–5].

The southern U.S. has been particularly subject to increases in abortion restrictions over the last 20 years. In comparison to the rest of the nation, abortion seekers in the South face urgent and extreme

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barriers to access [6]. As of 2021, abortion facilities in the South were serving almost three times as many women of reproductive age as those in the Northeast due to the limited number of clinics in the region underscoring geographic disparities in access to brick-and-mortar facilities [6]. Clinicians also face unique challenges practicing in the South, including issues with clinician recruitment and retention in the region that contribute to workforce shortages [7,8]. In addition, abortion seekers in the South face a high rate of strict, medically unnecessary requirements surrounding waiting periods, counseling, ultrasounds, and Targeted Regulations of Abortion Providers (TRAP) legislation disproportionate to the rest of the country [9–12]. As facility-based care in the South becomes more strained, telehealth medication abortion services could become more of an important option for maintaining access than ever before [13].

Telehealth abortion refers to the provision of medication abortion following a virtual clinician-patient interaction, which can involve a phone call, video call, secure messaging, email, or remote monitoring [13,14]. Telehealth abortion has the potential to provide a safe, effective method of terminating a pregnancy while also allowing patients to complete appointments in the comfort of their homes [15,16]. Telehealth abortion has also been found to be particularly beneficial in mitigating physical access barriers, abortion stigma and privacy-related barriers, and even financial barriers to care [16].

Legal restrictions on telehealth abortion vary across the South, as many states prohibit abortion altogether [17]. Advocacy for telehealth abortion is especially needed in southern states that still allow abortion but prohibit telehealth abortion. Few studies to date include information on the implementation needs and perceived benefits of telehealth abortion services, specifically in southern contexts, nor clinician and administrator perspectives of feasibility and readiness to implement these services. Including the perspectives of clinic administrators is critical to understanding feasibility and readiness, as administrators are primarily responsible for clinic operations and decisions. Given the rapidly changing abortion policy landscape in the South and the likelihood of continually decreasing access to services, exploring these perspectives is critical to developing a richer understanding of the telehealth abortion implementation landscape in the region. Using an implementation science lens highlights how priorities and attitudes may shape motivations or constraints on adopting a new practice [18]. The Consolidated Framework for Implementation Research (CFIR) identifies five domains of influence on the implementation of novel practices, including those related to the characteristics of the innovation: inner setting (the setting in which the innovation is implemented), outer setting (the external context in which the implementing organization exists), characteristics of individuals, and the implementation process and includes an examination of the perceptions of individuals related to the priority of the innovation [18].

Given the potential of telehealth abortion to expand access to care, this study fills a gap in the literature surrounding perspectives of sexual and reproductive health (SRH) providers (clinicians and administrators) in the South toward telehealth abortion services, including policy-based and population-based considerations. Using an implementation science framework, in this paper we sought to identify SRH provider attitudes related to the importance of and priority for implementing telehealth abortion services in the region.

2. Methods

2.1. Recruitment

This analysis was part of a larger study, the Provider Readiness for Virtual Implementation and Delivery of Medication Abortion Services (PROVIDA) study, that took place from June 2021–June 2022 and sought to assess the readiness of southern SRH clinicians and administrators to implement and offer quality telehealth abortion services within their professional practice. This paper focuses on a component of implementation readiness, clinician and administrator attitudes and perceived priority of telehealth abortion services. The study focused on two populations of SRH providers: (1) clinicians, including physicians and nurse practitioners, and (2) clinic administrative staff, including clinic managers, chief executive officers, etc. currently providing family planning services in the South. Clinicians and administrators were eligible to participate if they were engaged in providing medication abortion or family planning services at an abortion facility, specialized family planning center, or obstetrics and gynecology practice. Both those who were providing medication abortion services without telemedicine and those who were providing telehealth abortion were eligible to participate. We recruited participants through professional networks, professional listservs, and snowball sampling methods.

2.2. Data collection

Our study team used qualitative in-depth interviews to assess the readiness for and experiences with administering telehealth abortion from the perspectives of SRH clinicians and administrators. The interview guide included questions related to perceptions of state policies and all five domains of the CFIR including the extent to which participants viewed telehealth abortion to be a priority for their clinical practice (the focus of this analysis) [18]. The guide also included an example telehealth abortion protocol and walked participants through each step while probing about implementation considerations. Participants attended interviews via Zoom that ranged from 60 to 90 minutes and were compensated with a $50 gift card in recognition of their time. The research team audio-recorded interviews and began with administering an informed consent form followed by a short demographic questionnaire. The research team developed separate semi-structured interview guides for clinicians and administrators with common questions as well as specific questions relevant to their scope of work. The Emory University Institutional Review Board deemed this study exempt prior to data collection.

2.3. Analysis

We employed a thematic analysis method to analyze and interpret data [19]. The team uploaded professionally transcribed interviews to MAXQDA for coding and analysis and developed a codebook that included inductive and deductive codes from the interview guide and the CFIR framework, including five major domains and major constructs. Two team members coded a subset of transcripts to refine coding and ensure consistency and reached a final consensus on definitions through discussion with the full research team. For the purpose of this study, we examined the deductive implementation code “Relative Priority,” adapted from the CFIR. The CFIR defines this construct as “individuals’ shared perception of the importance of the implementation within the organization”; we adapted this to the study’s context and defined it as “individuals’ shared perception of the importance of implementing telehealth abortion services within the organization” [18]. The team used this code for statements from clinicians and administrators regarding perceptions of the need for telehealth abortion in response to questions about its importance and priority. The first author developed themes through memoing, thick description, comparison with the data, and discussion among the research team.

3. Results

We interviewed a total of seven administrators and 13 clinicians. The majority of participants worked at specialized family planning centers and were not providing telehealth abortion at their clinics. Table 1 further summarizes participant characteristics.

We identified four main themes: telehealth abortion is important for patient benefit, telehealth abortion is important for clinic benefit,

Table 1
Demographic characteristics of 20 sexual and reproductive health clinician and administrator interview participants practicing in the Southern U.S., 2021–2022

Demographic characteristics	*n* (%)
Role	
Clinician	13 (65)
Administrator	7 (35)
Organization Type	
Specialized Family Planning Center	12 (60)
Hospital	1 (5)
Virtual-Only Provider	3 (15)
Private Practice	3 (15)
Primary Care Clinic	1 (5)
State[a]	
Alabama	4 (20)
Florida	3 (15)
Georgia	6 (30)
Mississippi	1 (5)
North Carolina	4 (20)
South Carolina	1 (5)
Tennessee	3 (15)
Texas	2 (10)
Virginia	2 (10)
Current Telehealth Abortion Provider	
Yes	4 (20)
No	13 (65)
Partial Provision[b]	3 (15)

[a] Some participants practice in multiple states so numbers do not add up to 100.
[b] Provided at least one of the steps in telehealth abortion protocol.

the political climate affects personal prioritization of telehealth abortion, and staff hesitance affects clinic prioritization of telehealth abortion. Though perceived importance influenced feelings toward perceived priority for some participants, the two concepts were largely discussed separately.

3.1. Importance of telehealth abortion for patient benefit

3.1.1. Telehealth abortion mitigates barriers associated with physical access to care

Almost every participant cited the importance of implementing telehealth abortion to address physical access barriers to abortion care for patients. Participants noted that physical access barriers included living in a rural area and/or hours away from the nearest abortion clinic and having to cross state lines to receive care due to state restrictions and bans. Others discussed the barriers associated with the ability to physically get to a clinic and having to travel long distances, including the burdens of finding childcare, not having transportation, and the inability to take time off of work.

> *"It's really just access. It really helps access for people who have difficulty, for whatever reason, getting to the clinic. It allows people from all over the state to take advantage and to not have to travel." – Administrator, providing telehealth abortion*

Most participants also emphasized that vulnerable and marginalized populations in the South were at a disproportionately high risk of facing physical access barriers to abortion care and would thus especially benefit from telehealth abortion.

3.1.2. Telehealth abortion mitigates long wait times and other administrative barriers associated with internal and policy environments

Some participants specifically cited the importance of telehealth abortion in mitigating logistical and administrative barriers that may contribute to long wait times for care and increased patient burden. Participants highlighted that clinic barriers resulted from the concurrence of internal policies and external legislative requirements, such as state-mandated ultrasound and bloodwork requirements common in southern states. They noted long wait times during the appointment as well as for scheduling appointments as barriers to care for patients in the South particularly given clinician and clinic shortages.

> *"I have worked in several abortion clinics and they all take forever and it is a significant drain on patients' time … And the actual care that's provided takes, I mean, 45 minutes, I guess, start to finish, and yet they're with us for hours sometimes… telehealth could really help with that" – Clinician, partially providing telehealth abortion*

3.1.3. Telehealth abortion decreases cost of services for patient

Some participants cited the ability of telehealth abortion to decrease the cost of services for patients. These participants commonly noted that telehealth abortion services, especially if they eliminate the need for ultrasounds or bloodwork, have the potential to significantly decrease the amount that patients are required to pay for appointments.

> *"I think also in terms of potential costs to patients, it would definitely be a lot cheaper to administer or to do an online appointment* versus *the costs that are associated with coming in … in terms of benefits to the patient, they would also see those potential savings." – Administrator, not providing telehealth abortion*

Reducing such monetary costs in turn helps mitigate other financial barriers to care that patients face and ultimately allows for the potential of increasing access for economically disadvantaged patients.

3.1.4. Telehealth abortion increases patient privacy

Many participants mentioned the importance of telehealth abortion in allowing patients to have a safe, confidential abortion. Participants also cited the importance of privacy in avoiding abortion stigma in the context of protesters that are commonly stationed outside of abortion clinics in the South.

> *"Being able to order something to your front door and take a medication in the privacy of your own home and not have to go in and pass everyone who is outside picketing is a huge benefit." – Clinician, not providing telehealth abortion*

Additionally, participants discussed abortion stigma in the context of patient social circles as some participants mentioned that many patients do not feel safe or comfortable asking friends or family for support during the abortion process. Participants were optimistic about the ability of telehealth abortion to alleviate some of these issues.

3.2. Importance of telehealth abortion for clinic benefit

3.2.1. Telehealth abortion helps with staffing issues and clinic flow

Many participants cited the importance of telehealth abortion in potentially helping with staff efficiency issues, both from systems and administrative perspectives, as well as overall more streamlined clinic workflows. Participants discussed this in a variety of contexts, including eliminating the need for physicians to physically be at appointments.

> *"It would mean less of the physicians having to move around to get to some of the smaller clinics and make sure they got out there … I think there would be a lot of support for it administratively." – Clinician, not providing telehealth abortion*

A few participants cited that, especially in the South, clinics are often short-staffed and it can be difficult to find a physician to work on a regular basis. Participants noted the ability of telehealth abortion to alleviate this burden and to allow for more consistent staffing.

> *"Finding someone that wants to work on a regular basis can be a challenge, particularly in the South… so if we didn't have*

telemedicine to assist… yeah it would be bad." – Administrator, providing telehealth abortion

Participants also noted the potential for telehealth abortion to improve clinic flow, especially if it eliminates the need for unnecessary, time-consuming ultrasounds.

3.2.2. Telehealth abortion helps with clinic volume and sustainability

The majority of participants who noted the importance of telehealth abortion for clinic benefit did so in the context of sustainability. Sustainability included mentions of being able to see more patients, reducing expenses of flying physicians out to clinics, and avoiding the overhead costs of having an in-person clinic. Many participants who were already providing telehealth abortion also noted the benefits of having a purely virtual clinic.

"Our fees are about half of what they are in a clinic setting, and part of that is because we don't have to have the overhead of an office … so the ability to see a large number of patients … those savings are translated to the patient paying less." – Administrator, providing telehealth abortion

Participants also discussed the dual benefit to the clinic and patient given that telehealth abortion provision could translate to both an increase in revenue for the clinic and a decrease in the amount patients were required to pay for appointments.

3.3. Political climate affects personal prioritization of telehealth abortion

Almost every participant noted the political climate as the most important factor influencing their own prioritization of telehealth abortion at their clinic. While most participants cited it as the factor that made telehealth abortion less of a priority to them, a few conversely felt that the urgency of the political climate made their prioritization of telehealth abortion higher.

3.3.1. Legislative restrictions make telehealth abortion less of a priority

Despite acknowledging the medical and practical importance of telehealth abortion, most participants noted that the state restrictions and policies often negatively affected telehealth abortion priority. Participants noted deterring factors ranging from being unable to legally provide telehealth abortion in their state, to feeling confused with the rapidly changing policy landscape and not knowing the current legal status of telehealth abortion, to not wanting to risk implementing it for fear of it becoming illegal in the near future. Participants who expressed this view came from both less and highly restrictive contexts.

"I would say it's at the bottom of the priority list just because it is not feasible for us… if we didn't have that law or if there was any notion that that law was going to go away, then I think we would have definitely hopped on the tele-MAB train." – Administrator, not providing telehealth abortion

A few participants also noted that if they were to implement telehealth abortion, the nature of other abortion-related restrictions in their state would negate its benefits as it would not be a low-touch model in practice. In addition to legal hesitations, many participants also mentioned feeling so overwhelmed by the challenges that their current state-policy climate posed. Some participants discussed that given the challenges they faced both mentally and in trying to stay afloat given staffing and resource considerations, they did not consider telehealth abortion to be a high priority.

"My priority right now is just to make sure that we are providing the most safe and professional abortion services possible in person to our patients" – Clinician, not providing telehealth abortion

3.3.2. Fear of litigation makes telehealth abortion less of a priority

Many participants noted that fear of litigation kept them from prioritizing telehealth abortion. For example, some described fear of litigation as a result of unclear legislation in their state that could be interpreted to criminalize the provision of telehealth abortion. Participants mentioned that doing something new or innovative like telehealth abortion could bring unwanted attention from anti-abortion activists or legislators and in turn jeopardize their ability to provide in-person services. This theme was seen across multiple restrictive state contexts.

"When the state has organized private citizens to come after you about providing abortions, is it something you should be undertaking to try to skirt around the restrictions that are already in place? If that makes sense." – Clinician, not providing telehealth abortion

Many participants expressed that the risk of placing an "even larger target" on their backs ultimately outweighed the benefits of telehealth abortion.

3.3.3. Political climate makes telehealth abortion more of a priority

Most participants who were from less restrictive states cited the political climate as a factor in influencing their prioritization of telehealth abortion, with the majority of respondents saying they do not provide telehealth abortion at present. Among those not providing telehealth abortion, some participants cited the political context as creating a sense of urgency, thus making the consideration of telehealth abortion a higher priority, despite the logistical and legal challenges created by state laws. Participants who felt telehealth abortion was a priority, but were not currently providing, discussed the desire to launch services as soon as possible to increase availability of services for populations losing access as a result of newly restrictive policies in the South.

"I think with all of these policies bubbling up and really feeling … we've always known that there's been risk of rights being taken away at any moment, but actually feeling like it's maybe imminent. Right? I feel like now more than ever, I think it's crucial that we do learn how to provide tele medication abortion services" – Clinician, information not provided

A few participants reported that they have seen an uptick in both patient desire to utilize telehealth abortion and patients traveling further for care, influencing their urgent prioritization of implementing the service. Some participants noted that being able to provide telehealth abortion felt necessary given the imminent risk of abortion rights being stripped at any moment. Mention of telehealth abortion prioritization however did not necessarily translate to views on the feasibility of implementing these services given legal considerations.

3.4. Staff hesitance affects clinic prioritization of telehealth abortion

The most commonly mentioned factor affecting clinic prioritization of telehealth abortion was participant perception of other staff members' (including both clinicians and non-clinicians) hesitance and lack of prioritization. Many participants cited that, though they were in favor of telehealth abortion, they perceived that staff or administrators at their clinics were more nervous and hesitant to implement these services. Participants mostly described staff hesitance in the context of staff not wanting to change the ways in which they've done things at the clinic as well as being nervous to switch to a virtual format given fear of complications and not having an ultrasound. This likely stems from fears reinforced by unnecessary state-mandated requirements for abortion.

"We see all of the unicorns, so it's sometimes hard not to think of the unicorns. Everybody is like, "Well what if they have an ectopic," which is fair, but also not as common as people think necessarily." – Clinician, not providing telehealth abortion

Participant perception of staff prioritization of telehealth abortion at their clinic did not necessarily correlate with participant

attitudes toward the feasibility of implementing telehealth abortion at their clinic.

4. Discussion

Our study findings contribute to a more robust understanding of the telehealth abortion implementation landscape in the South and the unique considerations that SRH professionals in this region face. While other studies have examined implementation factors associated with the successful implementation of telehealth abortion services, they did not thoroughly address the priorities of those who would be implementing it [20]. This study explores how perceptions of relative priority for the implementation of telehealth abortion services might influence implementation in highly restrictive settings. Findings regarding the importance of telehealth abortion for patient benefit complement those of previous studies but with a specific focus on benefit to populations in the South [16,21,22].

Few studies cite the importance of telehealth abortion for clinic benefit, with those that do using data largely from states classified as having a "supportive" abortion policy climate. This research adds to current literature by providing perspectives specifically from the South and states with hostile abortion policies. This context is important given that abortion clinics in the South are under extreme strain in keeping their doors open, being able to meet patient demand, and maintaining regular staffing given a high risk of staff burnout and turnover [7,8]. Clinician recruitment and retention in the South is challenged by restrictive legislation, the institutional separation of abortion from other medical services, safety concerns, training unavailability, and marginalization within their profession that further contribute to issues with recruitment and retention [7]. The medical workforce in general also faces many challenges in the region [23]. According to the Association of American Medical Colleges, the South currently has the highest physician demand and projected demand growth of all U.S. regions [23]. Telehealth as a means to address medication abortion provision workforce challenges is a prominent finding of our work; these results may be applied to broader medical workforce issues in the South to assist with staffing consistency issues.

While existing literature documents the restrictions that abortion clinicians in the South face, few studies examine both clinician and administrator considerations of political and legal climate influence on the prioritization of telehealth abortion. Given that the majority of existing literature does not focus on these perspectives in restrictive settings, study findings regarding fear of litigation keeping providers from prioritizing telehealth abortion are prominent. It is important to note that those in abortion-supportive environments also fear having a "target" on their backs but that this feeling is exacerbated in more hostile environments.

Little existing literature examines the role of staff hesitance in clinic prioritization of telehealth abortion services. Previous studies have examined staff-reported barriers to the implementation of new practices in general, complementing the findings of this research [24]. Given existing challenges with staff shortages and high staff turnover and its implications in abortion and family planning contexts in the South, careful attention should be paid to addressing staff concerns and involving them in implementation planning [7,25].

One notable limitation of this study is that data was collected before the *Dobbs v. Jackson Women's Health Organization* decision that drastically altered the abortion access landscape in the U.S.; in many states represented in the sample, abortion is now banned. However, findings from this study provide valuable insight from those who were already in restrictive environments and have important implications for motivating clinicians and staff to implement telehealth abortion. We believe that these findings would hold in a post-*Dobbs* environment; given the highly restrictive abortion access landscape, clinicians may be more concerned with following state law but may be more open to experimentation as well. Another limitation of this study is that recruitment was done through professional networks, listservs, and snowball sampling, potentially leading study participants to be disproportionately supportive of telehealth abortion. Further, we interviewed more clinicians than administrators, which may have led participants to be disproportionately optimistic about telehealth abortion as a means to support clinic sustainability. Finally, heterogeneity in telehealth abortion provision may have limited the research design given that some participants had experience providing telehealth abortion while others had none.

A major strength of this study is its incorporation of multiple states across the South, all of which have restrictive policy climates for abortion care. Further, this study extended research on telemedicine to both those interested in and those who had provided the service, thus covering a wide variety of opinions and ideas around implementation. Finally, this study is one of the first to apply an implementation science framework to the concept of telehealth abortion; this lens has the distinct advantage of allowing research to be translated into effective practice.

Evidence of the potential for telehealth abortion to mitigate a myriad of barriers for patients and providers is growing and telehealth abortion implementation is only more urgent as bans continue to erode the SRH workforce and brick-and-mortar services in southern contexts. This study explored how SRH providers prioritize the potential to implement telehealth abortion and provides an understanding of how the priority of potential implementers may influence implementation overall. Our work highlights that state political climate, not just the restrictions enacted, but also provider perception of their scope of practice within their state, is a crucial factor in influencing prioritization of telehealth abortion and may stifle innovative thinking in this area as well as efforts to implement unbundled telehealth abortion services in the South. Providers may first face other restrictions like waiting periods, ultrasound requirements, targeted regulations of abortion providers legislation, and informed consent as hurdles before considering the ability to implement telehealth abortion. Advocates and providers may work toward addressing general restrictions to abortion access as well as specific restrictions that make telehealth abortion implementation less feasible. In the event that telehealth abortion implementation is no longer legally feasible in southern states, clinicians and administrators could focus on workarounds such as unbundling components of telehealth like pre-screening and counseling services or post-abortion follow-up care and incorporating telehealth abortion into already existing telehealth contraceptive services.

Staff hesitance due to fear of litigation as a factor influencing clinic prioritization of telehealth abortion has implications for recommendations for staff training on and education about telehealth abortion and its evidence-backed safety and effectiveness as well as encouraging involvement of staff in the implementation process. Future research should further investigate the potential to implement telehealth abortion in the South and how best to engage providers in the process. This study also highlights that implementation of telehealth abortion services may be less of a priority when clinicians and administrators are focused on ensuring overall abortion access. As abortion access is a human right, there is a need for continued provider-community partnerships and collaboration between providers in protective and restrictive states to ensure that abortion care may be accessible for southern patients, irrespective of whether abortion care is feasible to be performed via telehealth services.

Author contributions

S.N.: Writing – review & editing, Supervision, Project administration, Methodology, Funding acquisition, Data curation. A.N.-L.: Writing – review & editing, Supervision, Project administration,

Methodology, Funding acquisition, Data curation. P.B.: Writing – review & editing, Writing – original draft, Investigation, Formal analysis, Conceptualization.

Declaration of Competing Interest

We attest that we have no conflicts of interest to declare for this research.

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