

# The Patient's View of the Role of the Primary Care Physician in Abortion

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To what extent do women turn to their physicians for counseling or service when they suspect or know that they have unwanted conceptions? While the Supreme Court ruling of 1973 made the abortion decision a matter between a woman and "her physician," how does she define "her physician" when she is making that decision?

This paper utilizes data from a study of women with unwanted conceptions which was conducted throughout Michigan in 1974-75. The sample was 1746 women; 561 bore their child and 1185 had abortions. The part reported here consists of those who chose abortion and who answered "yes" to the question "Do you have a regular doctor to whom you usually go when you need medical care?" (N = 940).

A two-stage stratified sampling design was used: 1) sampling organizations which served women with unwanted conceptions,\* and 2) sampling on a time basis women served by these organizations. Cooperation was obtained from 84 per cent of the organizations and 93 per cent of the women. Data were obtained through an anonymous, self-administered questionnaire.

## Findings

Only 17 per cent turned to their physician for advice when they first thought they might be pregnant (Table 1). Only 41 per cent went to their physician to find out whether they were pregnant (Table 2). Even though 44 per cent said they made the decision entirely on their own to have an abortion, many people were influential in the subjects' process of decision-making (Table 3). The only truly important resource for the women in their time of decision-making was the male partner.

Subjects answered a 13 item scale directed toward finding out how much conflict they had in making their decision to have an abortion. Responses ranged from 1 (agree completely) to 4 (disagree completely). As recoded for analysis, 4 represented the most conflict and 1 the least. The mean of the recoded responses was each individual's score. Women whose physician played a part in the decision-making had more conflict on the average ( $\bar{X} = 2.44$ ) than did others ( $\bar{X} = 2.26$ ,  $t = 2.51$ ,  $p = .01$ ).

Such overall results may obscure the physician's role

among important subcategories, however. For instance, women who obtained first trimester abortions in clinics were compared to those who had first trimester abortions in hospitals. To control for effects of trimester, the 207 second trimester patients were omitted from this analysis. It was reasoned that the physician should be more significant to women having first trimester abortions in hospitals than to those having them in clinics, since, if a woman's own physician were to perform the abortion, it typically would be in a hospital. Of those having a first trimester abortion in a hospital, 52 per cent went to the particular hospital they did because of their physician, while only 16 per cent of non-hospital aborters selected the place to which they went on their physician's recommendation.

The physician's role in clinic selection was not unimportant, however. Of the 16 per cent who chose a clinic on their physician's recommendation, significantly more went to

**TABLE 1—Respondent Source of Advice When Pregnancy Was Suspected**

Source of Advice*	N	%
1. No one	387	41
2. Male Partner	288	31
3. Friend	203	22
4. Physician	160	17
5. Sister	63	7
6. Counseling Service	65	7
7. Mother	59	6
8. Other	20	2

\*Percentage of respondents who answered "Yes" when asked whether or not they sought advice from a given source. (For Source 1, respondents were asked: "When you first thought you might be pregnant but weren't sure, did you try to get advice from anyone about what to do?" For Sources 2-8, they were asked: "From whom did you try to get advice?")

**TABLE 2—Percentages of 940 Respondents Utilizing Various Sources To Confirm Their Pregnancy**

Source	%
1. Primary Care Physician	41
2. Abortion Clinic	20
3. Unknown Private Physician	13
4. Free Clinic	11
5. Mixed Sources	8
6. Unknown Hospital MD	4
7. School Health Service	2

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**TABLE 3—Percentages of Respondents by Source and Strength of Influence on their Decision to Abort**

Influence Source	A Lot		Influence Strength* Some		None	
	N	%	N	%	N	%
1. Male Partner	260	31	180	21	406	48
2. Girlfriend	61	7	112	13	671	80
3. Mother	78	9	76	9	690	82
4. Physician	59	6	54	6	741	88
5. Sister	35	4	45	5	764	91
6. Father	36	4	34	4	773	92
7. Counseling	5	1	35	4	797	95
8. Other	22	3	8	1	814	96

\*Percentages are adjusted for missing data. They total more than 100 per cent because respondents could give more than one answer.

“women-centered clinics”\* (69 per cent) than to “commercial clinics” (31 per cent). When women found clinics through other sources, only 35 per cent went to “women-centered clinics.”

Significantly more hospital than non-hospital aborters also got advice from their physician when they first thought they might be pregnant (22 per cent vs. 15 per cent, Chi-Square = 3.97, 1 DF,  $p = .05$ ) and went to their regular physician for confirmation of their pregnancy (54 per cent vs. 35 per cent, Chi-Square = 22.04, 1 DF,  $p = .0001$ ). The physician’s influence on the decision to have an abortion did not differ significantly between the two groups, however.

When comparing first and second trimester aborters, it was found that trimester did not differentiate in terms of source of advice, source of influence or where the pregnancy was confirmed.

Although the physician was involved in only a minority of cases, significantly more first trimester patients went to the place they did because of their physician’s referral than was so for second trimester subjects (26 per cent vs. 18 per cent, Chi-Square = 47.01, 4 DF,  $p = .001$ ).

The average first trimester patient who was influenced by her physician had significantly more conflict than those not so influenced ( $\bar{X} = 2.45$  vs.  $\bar{X} = 2.21$ ,  $t = 2.79$ ,  $p = .005$ ). Second trimester aborters who were influenced by their physician did not have a significantly different amount of conflict ( $\bar{X} = 2.41$ ) than those who were not influenced ( $\bar{X} = 2.45$ ).

\*The sampling frame was developed after an extensive effort to list all institutions and agencies offering abortion services in the state. The final sample of abortion facilities consisted of nine free-standing clinics in Metropolitan Detroit, four clinics in outstate Michigan, seven hospitals in Metropolitan Detroit, and five in outstate Michigan.<sup>1</sup>

\*\*“Women-centered clinics” were defined as those approved and/or operated by Clergy Counseling Service, Planned Parenthood, National Organization for Women, or Feminist Health Centers. The remainder were “commercial clinics.”

## Discussion

A majority of the women did not perceive their primary care physician as a resource when they had to cope with unwanted conceptions. The data do not provide an answer as to why this was so, but other sources of information may suggest some interpretations. Surveys have documented the existence of extensive negative feelings toward abortion among physicians, as well as the fact that physicians have tended to lag behind the general population in their attitudes.<sup>2-13</sup> Women may have avoided going to their own physician for services in order to prevent anticipated negative influence on their decision or negative sanctioning of a decision they already had made. On the other hand, they may have been ashamed. In any case, the hiatus between many women with unwanted conceptions and their physicians may have serious consequences. A major consideration among subjects was the effect their choice might have on their health. Women might like their own physician to discuss with them the impact of abortion on their health, and to recommend organizations, but to avoid participation in decision-making per se.

Physician involvement was associated with both conflict and delayed abortion, but the data do not permit one to determine whether involvement was a cause or result of such conditions.

Physicians were relatively important resources when compared to family members or other professionals, but were more important in providing service than for counseling. One area in which primary care physicians might increase their activity and in which they could make an important difference in their patients’ well-being is in directing them to adequate facilities for service.

## Summary

Data from a Michigan-wide study of women with unwanted conceptions conducted in 1974-75 indicate that most

women did not turn to their physician for any kind of assistance in dealing with their situation. The physician was utilized more for service or referral than for counseling. When compared to other sources of influence on the decision to abort, primary care physicians were found to be *relatively* important.

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## Should There Be a Different Definition of Anemia In Black and White Children?

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While there has been no unanimity in deciding what level of hemoglobin concentration shall be used to arbitrarily define anemia in infants and young children, most working groups have accepted levels between 10.0 and 11.0 gm/dl depending upon age.<sup>1-5</sup>

From data collected in the Preschool Nutrition Survey,<sup>6</sup> which was based upon a national probability sample of U.S. children between 1 and 6 years of age, Black children were found to have a hemoglobin level which averaged about 0.5 gm/dl lower than White children of comparable age and socioeconomic status.<sup>7</sup> Similar observations have been made among several thousand young children studied in the Ten-State Nutrition Survey<sup>8</sup> and in the Health and Nutrition Examination Survey.<sup>4</sup>

Among 1,755 White children and 266 Black children in the Preschool Nutrition Survey<sup>6</sup> who had serum iron and total iron-binding capacity determined, 1,241 and 163, respec-

tively, had transferrin saturations equal to or greater than 16 per cent.\* Probability plots of hemoglobin concentrations are shown (Figure 1) for Black and for White youngsters between 12 and 71 months of age, who were included in the Preschool Nutrition Survey and whose transferrin saturations exceeded 15 per cent. As may be seen, the 50th percentile hemoglobin values were 12.1 and 12.6 gm/dl respectively, for Blacks and for Whites. This approximate 0.5 gm/dl difference between Blacks and Whites also existed at the 5 per cent level, i.e., the level commonly used to distinguish between "normal" and "anemic". With the exclusion of children with low levels of transferrin saturation (< 16 per cent), Black and White children still differ in hemoglobin levels and it appears to be a simple displacement of the distribution curves rather than shifts or alterations in their characteristics. Further, the distribution of serum irons, total iron-binding capacity and transferrin saturations among these Black and White children were the same. As may be appreciated, the distribution of hemoglobin values for all Blacks in

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\* A state of iron deficiency was considered to exist with a transferrin saturation below 16 per cent.