Attitudes and Preferences Toward the Provision of Medication Abortion in an Urban Academic Internal Medicine Practice

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BACKGROUND: Mifepristone offers internal medicine doctors the opportunity to greatly expand access to abortion for their patients. Almost 70% of pregnancy terminations, however, still occur in specialized clinics. No studies have examined the preferences of Internal Medicine patients specifically.

OBJECTIVE: Determine whether patient preference is a reason for the limited uptake of medication abortion among internal medicine physicians.

PARTICIPANTS: Women aged 18–45 recruited from the waiting room in an urban academic internal medicine clinic.

MEASURES: A semi-structured questionnaire was used to determine risk of unintended pregnancy and attitudes toward abortion. Support for provision of medication abortion in the internal medicine clinic was assessed with a yes/no question, followed by the open-ended question, "Why do you think this clinic should or should not offer medication abortion?" Subjects were asked whether it was very important, somewhat important, or not important for the internal medicine clinic to provide medication abortion.

KEY RESULTS: Of 102 women who met inclusion criteria, 90 completed the survey, yielding a response rate of 88%. Twenty-two percent were at risk of unintended pregnancy. 46.7% had had at least one lifetime abortion. Among those who would consider having an abortion, 67.7% responded yes to the question, "Do you think this clinic should offer medication abortions?" and 83.9% stated that it was "very important" or "somewhat important" to offer this service. Of women open to having an abortion, 87.1% stated that they would be interested in receiving a medication abortion from their primary care doctor.

CONCLUSIONS: A clinically significant proportion of women in this urban internal medicine clinic were at risk of unintended pregnancy. Among those open to having an abortion, a wide majority would consider receiving it from their internal medicine doctor. The provision of medication abortion by internal medicine physicians has the potential to greatly expand abortion access for women.

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BACKGROUND

In September 2000, the FDA approved mifespristone for commercial use, with misoprostol, to induce abortion. This regimen for medication abortion had the potential to expand access to abortion services to settings other than specialized abortion clinics. The number of abortion providers, which had decreased from 2,380 in 1992 to 1,819 in 2000,[1] was expected to rise dramatically. Instead, after the approval of mifepristone, the number of abortion providers continued to fall, to 1,787 in 2005, and remained flat at 1,793 in 2008. The most recent data available show that the vast majority of abortions (70%) are still performed in specialized clinics, with only 1% of abortions performed in the primary care setting by non-ob-gyn providers.[2,3]

Given that medication abortion has been shown to be safe and effective,[4] it remains unclear why there has been such limited uptake in the primary care setting. Some possible hypotheses include 1) lack of confidence by primary care physicians (PCPs) in their own ability to safely administer medication abortion, 2) the need for PCPs to register as abortion providers and distribute mifepristone themselves in the clinic, rather than merely write a prescription, 3) lack of confidence by patients in the ability of primary care physicians to provide abortion care, 4) perception by primary care doctors that there is sufficient access to abortion in specialized clinics, and 5) patient discomfort with receiving an abortion from a doctor who knows them, and with whom they will have an ongoing relationship.

There has been prior research on this topic from both the physician and patient perspectives. A study of 212 resident physicians showed that 84% of family medicine residents, but only 42% of internal medicine residents, would be comfortable providing mifepristone for medication abortion.[5] This study was performed soon after the approval of mifepristone in the U.S., and attitudes may have changed as

familiarity has increased. A survey of older ob/gyns and PCPs (median age=49), however, showed that PCPs were three times less willing to consider offering medication abortion than ob/gyns.[6] These data suggest that while some primary care physicians are willing to prescribe mifepristone, there appears to be a difference in comfort level between physician specialties.

Previous research on patient perspectives indicates a high level of support for medication abortion in the primary care setting in urban areas. Among 449 women surveyed in an inner-city family medicine clinic, 69% expressed support for the use of medication abortion in that setting.[7] A two-city study of 299 women at abortion clinics found that 58% would prefer to receive an abortion from their primary care doctor than from a specialized clinic.[8]

Support is even greater among women who have already used medication abortion to terminate a pregnancy. One study, although not performed in a primary care setting, showed that of 1080 women who received medication abortion, 89.7% would use it for a future abortion if needed.[9]

In contrast, a study performed in a non-urban Midwestern setting showed much lower acceptability rates for abortion provision in primary care practices.[10] Of 205 patients at a Planned Parenthood in Iowa, 65% stated they would not have gone to their primary care doctor for an abortion. The 20% who said they would go to a generalist were older, had been to Planned Parenthood before, were less likely to have health insurance that covered abortion, and had a significantly longer travel time to get to the abortion clinic.

No published studies of abortion in the primary care setting have focused on internal medicine (IM) patients specifically. There are several reasons why IM patients need to be considered as a separate population. First, women who visit an IM physician regularly are more likely to have a chronic illness that requires regular doctor visits. These recurrent visits may build a feeling of closeness and trust, which could lead the patient to be more willing to receive a medication abortion from her IM doctor.[11] Second, there may be a perception among patients that IM doctors lack competence in gynecological issues. In a study by Rubin et al.,[7] some women expressed concerns about whether their family doctor had the skills to offer abortion care; this concern may also be relevant to women in an IM setting.

Our primary goal was to assess 1) demographic characteristics, 2) contraceptive and sexual histories, and 3) abortion preferences of reproductive-aged women in our urban IM clinic. Our secondary goal, by comparing our data with the existing reproductive health literature, was to determine whether the characteristics and preferences of IM patients are similar to those of women in other primary care settings.

METHODS

Setting and Study Participants

The study was performed at the internal medicine clinic at the Comprehensive Health Care Center, a Community Health Center in the South Bronx, NY. The clinic provides primary care services in distinct departments of internal medicine, ob/gyn, and pediatrics.

To be considered for inclusion, patients had to be between 18 and 45 years old, female, speak either English or Spanish, and be registered patients in the IM clinic. Pregnancy was not an exclusion criterion.

Subjects were recruited consecutively from the waiting area of the IM clinic. Approximately one half of the subjects were recruited in December 2008 and January 2009, and the other half were recruited in June and July 2009. Data were collected during both morning and afternoon sessions. Every woman who met inclusion criteria, and who presented to the clinic during sessions when research was being conducted, was offered participation in the study. The paper survey was administered in a private room by a trained research assistant. The survey was offered in English and Spanish.

No identifying information was recorded on the surveys; each participant was assigned a three-digit numerical identifier, which was written on the paper survey and transcribed into the database. Consent was obtained orally. The study was approved by the Institutional Review Board of Montefiore Medical Center.

Subjects received no financial or other compensation for participation in the study. Paper surveys used to record data were transcribed daily into an electronic database, and the originals stored in a locked file cabinet.

Survey Instrument

The survey was adapted from one that was created to assess the acceptability of medication abortion in family medicine clinics. The initial survey was developed by a team of physicians with expertise in family planning care, along with a member of the research division who has extensive experience in survey development. The survey was piloted, and the prior study implemented, at a family medicine clinic less than two miles from where our study was performed. During the piloting phase women were asked for feedback regarding the clarity of the questions.

The survey was a 43-item semi-structured questionnaire that took 5–10 minutes to complete. Forty questions were closed-ended and three questions were open-ended. Responses to the open-ended questions were coded on-site into pre-assigned categories.

Risk of unintended pregnancy was assessed in those subjects who had had vaginal intercourse with a man in the

past three months, and who did not express a desire to get pregnant. These subjects were asked "In the past three months, what types of birth control have you used?" If condoms or any type of hormonal contraception were reported, subjects were asked "How often did you use (condoms/birth control pills/patch/ring)?" Subjects that answered "sometimes" or "rarely" were classified as being at risk of unintended pregnancy.

Knowledge of medication abortion was assessed with the following question: "Have you ever heard of medication abortion? It's also called the abortion pill or RU-486." If necessary, a brief description of the process, including its risks and benefits, was provided. Respondents were then asked, "Do you think this clinic should or should not provide medication abortion for our patients?" An open-ended follow-up question, "Why do you think this clinic should (or should not) provide medication abortions?" allowed respondents to give their reasons for either supporting or not supporting medication abortion in the IM clinic.

We assessed general attitudes toward abortion with the question, "If you were pregnant and unsure about what to do, would abortion ever be an option for you?" Finally, subjects were asked a hypothetical question: "I'd like you to imagine that you became pregnant in the future, and you decided to have an abortion. If you knew that the CHCC internal medicine clinic offered abortions, would you consider having your abortion here?"

Data Analysis

Information collected during the study was analyzed using the statistical program Stata (Statacorp, College Point, Texas). Associations between all demographic variables and attitudes and preferences toward medication abortion were assessed. The X2 test was used for comparisons of dichotomous variables, and the Student's *t*-Test was used to compare continuous variables.

RESULTS

Demographics

Demographic data of participants is shown in Table 1. Of 102 women who met criteria and were offered participation, 90 completed the survey and 12 declined to participate. All subjects were Black or Hispanic. Seventy-three subjects (81.1%) were publicly insured or self-pay patients. Three subjects stated that they were Spanish-English bilingual, and 1 subject reported French as her primary language, but appeared fluent in English and took the survey without any comprehension difficulties.

Table 1. Demographic Characteristics of Survey Respondents by Abortion History

Characteristic	No history of abortion	One or more abortions	All Respondents
	N=48	N=42	N=90
Mean age, years	31.6	34.2	32.7
Race/Ethnicity			
White Non-Hispanic	0 (0)	0 (0)	0 (0)
Hispanic			
Puerto Rican	13 (27.1)	12 (28.6)	25 (27.8)
Dominican	10 (20.1)	2 (4.8)	12 (13.3)
Mexican	3 (6.3)	3 (7.2)	6 (6.7)
Black	22 (45.8)	25 (59.5)	47 (51.1)
Primary Language			
English	33 (68.8)	34 (81.0)	67 (74.4)
Spanish	14 (29.2)	6 (14.3)	20 (22.2)
Bilingual / Other	2 (4.2)	2 (4.8)	4 (4.3)
Marital Status			
Never married	32 (66.7)	25 (59.5)	58 (64.4)
Married or living with partner	7 (14.6)	8 (19.0)	15 (16.7)
Divorced or separated	9 (18.8)	9 (21.4)	18 (20.0)
Insurance			
Fee-for-service	7 (14.6)	7 (16.7)	14 (15.5)
Medicaid			
Managed Medicaid	30 (62.5)	24 (57.1)	54 (60.0)
Private insurance	8 (16.7)	8 (19.0)	17 (18.9)
Self-pay	3 (6.25)	3 (7.1)	6 (6.7)
Self-report "regular patient" in internal medicine clinic	43 (89.6)	34 (80.1)	77 (85.5)

Reproductive Health History

Reproductive health data is shown in Table 2. The vast majority of subjects had visited both an IM doctor (96.7%) and a gynecologist (97.8%) in the past three years. 67 respondents (74.4%) said their gynecologist was in the same building where the IM clinic was located, and 21 used an outside gynecologist (23.3%).

Table 2. Reproductive Health History of Survey Respondents (n=90)

Characteristic	N (%)
Pap smear in past 3 years	83 (92.2)
Internal medicine clinic	7 (7.8)
ob/gyn clinic	61 (67.8)
Family medicine clinic	15 (16.7)
Vaginal intercourse in past 3 months (not trying to get pregnant)	64 (71.1)
Types of contraception used	
Condoms	33 (36.7)
Birth control pills, patch, ring	14 (15.6)
Tubal ligation / hysterectomy	17 (18.9)
IUD	3 (3.3)
At risk of unintended pregnancy	20 (22.2)
Heard of emergency contraception	67 (74.4)
Used emergency contraception in past year	12 (13.3)
One or more lifetime pregnancies	68 (75.6)
Median pregnancies	3 (range 0–11)
One or more lifetime abortions	42 (46.7)
Location of abortion	
Planned Parenthood	13 (31.0)
Other specialized clinic	29 (69.0)
Primary care clinic	0

Fifty-one subjects (56.7%) stated that a physician had discussed birth control options with them during the past 12 months. For 28 of these subjects, birth control was brought up only by their gynecologist, and for nine subjects it was brought up only by their IM doctor. Fourteen women said they discussed birth control with both an IM doctor and a gynecologist. Among the 20 women at risk of unintended pregnancy, 14 had discussed birth control with their doctor in the past year (70.0%). Six discussed birth control with their ob/gyn, five discussed it with an IM doctor or pediatrician (one patient), and three discussed it with both ob/gyn and IM doctors.

Among those subjects who reported having vaginal intercourse in the past three months, one woman was currently pregnant, and nine were trying to get pregnant (12.3%). Among the 80 women not trying to get pregnant, four used more than one form of birth control, and seven used no birth control. Of the 33 women who reported using condoms for birth control, 13 reported using them "sometimes," and one used them "rarely." Of the 14 women using birth control pills, five reported inconsistent usage.

Twenty-one women had a history of one abortion, twelve women had two abortions, and nine women had three or more abortions. All abortions were procedures; no medication abortions were reported.

Reproductive Health Knowledge and Preferences

Table 3 shows subjects' attitudes toward abortion. Of the 31 women who would consider abortion, 83.9% stated that it was either "very important" or "somewhat important" for the IM clinic to offer medication abortion. 27 of these 31 women (87.1%) indicated that they would consider having a medication abortion at this IM clinic. 56 women were unaware of medication abortion as an option (62.2%), while 34 women had heard of it (37.8%).

Of note, there was significant support for medication abortion even among those women who stated that it would never be an option for them. Of the 47 women who responded that abortion would "never be an option", over half supported offering it in this IM clinic.

Fifty-two of 90 respondents (57.7%) stated that this IM clinic should offer medication abortion. Reasons most commonly given were: "women deserve abortion options" (41 times), "prefer to see regular doctor or nurse practitioner" (nine times), "no need to go to another facility" (eight times), and "bad experience with previous abortion provider" (two times).

Twenty-one of 90 respondents (23.3%) stated that this IM clinic should not offer medication abortion. The single most commonly given reason was "abortion goes against my beliefs" (18 times, 85.7%). Four subjects opposed to medication abortion stated they "would not want my regular doctor to know," and one cited "bad experience with previous abortion provider" as a concern.

No subjects, regardless of their opinion about abortion, cited either cost or physician competence as a concern.

No statistically significant associations were found throughout the data.

Table 3. Attitudes and Preferences Toward Abortion

	Open to having an abortion*	Not open to having an abortion*
	N=31 (%)	N=47 (%)
Should this internal medicine clinic offer medication abortion?		
Yes	21 (67.7)	27 (57.4)
No	4 (12.9)	16 (34.0)
Don't know	6 (19.4)	4 (8.5)
How important is it for this internal medicine clinic to offer medication abortion?		
Very important	15 (48.4)	12 (25.5)
Somewhat important	11 (35.5)	13 (27.7)
Not important	3 (9.7)	13 (27.7)
Don't know	2 (6.5)	9 (19.1)
Would you consider having an abortion at this internal medicine clinic?		
Yes	23 (74.2)	16 (34.0)
Maybe	4 (12.9)	4 (8.5)
No	4 (12.9)	14 (27.7)
Don't know	0	13 (23.4)

**Based on response to the question "If you were pregnant and unsure about what to do, would abortion ever be an option for you?"*

DISCUSSION

To our knowledge, this is the first study examining the abortion preferences of internal medicine patients. Our goal was to assess reproductive health behaviors and preferences of this subset of the population. We found rates of sexual intercourse, contraceptive use, and abortion use similar to studies performed in family medicine settings, and consistent with regional and national trends.[2,12]

We found widespread support for the provision of medication abortion in the IM setting. Support was strongest among women who were open to having an abortion themselves, with nearly nine out of ten women stating that IM doctors should offer this service.

These findings are particularly notable in light of the fact that nearly all respondents had visited a gynecologist in the past three years, and two-thirds considered themselves "regular patients" at their gynecology clinic. Why would so many patients who regularly see a gynecologist consider having an abortion at an IM clinic? Possible hypotheses include women having a closer relationship with their IM doctor, or the relative ease of making appointments at the primary care clinic versus the gynecologist. Finally, it is

possible that respondents may simply like having the option of receiving medication abortion in the IM clinic. Further research is needed to elucidate these questions.

Our results differ significantly from a similar assessment of attitudes and preferences performed in Iowa in 2008.[10] In that study, only 20% of women stated that they would feel comfortable receiving an abortion from a generalist practitioner. There are three likely explanations for the differences between our findings. First, there may be geographic and regional differences in abortion preferences. Our study was performed in the largest city on the East coast; the Iowa study was performed in multiple small- to medium-sized towns. Second, our study was performed in a primary care clinic, and was therefore more likely to include women comfortable receiving services from primary care doctors. The Iowa study, which was performed at Planned Parenthood clinics, may have sampled women with a preference for specialized abortion centers. A third factor is the relative scarcity of abortion providers in Iowa compared with the Bronx, which may have led women in Iowa to believe that specialty clinics were the only "appropriate" place to receive abortions.

More than half of the women we spoke with stated that no type of abortion would ever be an option for them. As such, it was difficult to assess whether these women would consider receiving an abortion from an IM doctor. Further study of this subset of patients is needed, because data suggests that women who are theoretically opposed to abortion constitute a significant proportion of abortion users.[12,13]

Less than one quarter of respondents opposed medication abortion in the IM clinic, and this opposition was overwhelmingly based on general beliefs about abortion, rather than specific beliefs about the IM clinic. Perception of greater expertise in a specialty clinic, one of the hypotheses we set out to explore, was not cited as a reason for opposition to medication abortion. Furthermore, no respondents gave the opinion that medication abortion is not within the purview of internal medicine.

We hypothesized that the doctor–patient relationship might play a role in limited uptake of medication abortion in the IM clinic, since some women would not want their primary care provider to know about their abortion. We did find that one-fifth of those who opposed abortion in general said they would not want their doctor to know about their abortion. Among those who supported medication abortion in the IM clinic, however, one-fifth cited the ability to receive it from their primary care doctor as a positive feature. These data suggest that a strong doctor-patient relationship could be helpful in encouraging uptake of medication abortion among those women most likely to use it. Larger studies should examine the role of the doctor–patient relationship in more detail.

Women who stated that they themselves would never have an abortion still supported the idea of the IM clinic providing abortions. This may simply reflect a degree of sympathy with women who hold views different than their own. It may also, however, suggest that even women opposed to abortion would like to have the option available in case they change their minds. The latter hypothesis is supported by our data: among the 47 women who stated they would never have an abortion, 20 also stated that they would theoretically consider having an abortion at the IM clinic. This finding should be interpreted with caution, however, since the question asked women to start from the assumption that "you decided to have an abortion."

The number of women we report as being "at risk of unintended pregnancy" is likely an underestimation. Risk of unintended pregnancy was determined by the numbers of patients reporting inconsistent condom or hormonal contraception use, plus those patients reporting no contraceptive use at all. Faced with a medical professional asking questions, and knowing what the "right" answer was, it is likely that subjects over reported their adherence to condoms and hormonal contraception.

One finding of concern, given the risk of unintended pregnancy noted above, is the fact that only one-fourth of our subjects had spoken with an IM physician about contraception in the past year. This may in part be explained by the existence of an ob/gyn department in the same building: nearly twice as many subjects had spoken with an ob/gyn about contraception. Before this IM clinic can address abortion needs, however, an increased attention to general reproductive health would need to take place, despite the fact that medication abortion can be provided by just a single physician in a practice.

A number of external obstacles could discourage IM physicians from starting to offer medication abortion. First, although New York uses state funds to cover abortion services, 32 states and the District of Columbia do not. Second, a medical liability insurance rider for medication abortion has cost other physicians $10,000 to $15,000 per year.[14] Third, medication abortion has a success rate of 92 - 99%,[15,16] requiring back-up from a provider with skills in uterine aspiration in cases of failure.

One major limitation of this study is the sample size, which did not allow sufficient power to perform logistic regression analysis on the data. As a result, it remains unclear whether certain demographic characteristics (religion, income, age, self-report as a "regular" patient) are correlated with support for offering medication abortion in the IM setting. In order to more fully characterize the attitudes and preferences of various subsets of this population, larger studies of reproductive-aged women visiting IM clinics should be done.

Another important limitation is the generalizability of this data. All participants in the study were Black or Hispanic, and most were publicly insured or self-pay patients. Although this is highly representative of the community from which the sample was drawn, the views of these

patients may not be generalizable to other communities of reproductive-age women.

There are several other minor limitations to this study. Our interview process may have created selection bias. The waiting area of the clinic was often crowded, and to participate women had to enter a private room and lose their seat. We anecdotally observed that of the 12 women who declined participation, most had multiple children and strollers. The inconvenience of temporarily leaving the waiting area may have been a factor in this decision.

We did not assess chronic illness and its severity in this study. Some of our subjects were undoubtedly coming to the clinic for chronic disease management, while others had no significant past medical history and were coming for preventive care, vaccinations, or pre-employment physicals. Subjects were recruited consecutively, and it is theoretically possible that the proportion of chronically ill patients in our sample was not reflective of the clinic's overall population.

Our data suggest that a clinically significant proportion of women would be comfortable receiving medication abortion from an IM physician. Although this is a preliminary study with a small sample size, the hypothesis that patient preference explains the limited uptake of medication abortion in primary care is, given our findings, very unlikely. Other factors, such as IM physicians' lack of comfort with medication abortion, should be explored as a cause of this limited uptake.

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