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Factors Shaping Women's Pre-abortion Communication with Their Regular Gynecologic Care Providers

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A B S T R A C T

Objective: To understand women's experiences communicating with their regular gynecologic care provider about abortion decision making before obtaining an abortion at a dedicated abortion clinic.
Study Design: Semistructured interviews were conducted with women presenting for first-trimester surgical abortion at a high-volume, hospital-based abortion clinic. Women were asked whether and why they did or did not discuss their abortion decision with their gynecologic care provider. Interviews were transcribed and computer-assisted content analysis was performed; salient themes are presented.
Results: Thirty women who obtained an abortion were interviewed. A majority of the 24 women who had a regular gynecologic care provider did not discuss their decision with that provider. Themes associated with not discussing their decision included: 1) perceiving that the discussion would not be beneficial, 2) expecting that gynecologic care providers do not perform abortions, 3) anticipating or experiencing logistical barriers, and 4) worrying about disrupting the patient–provider relationship. Women who did discuss their decision primarily did so because the pregnancy was diagnosed at the time of a previously scheduled appointment and generally did not believe that their provider performed abortions.
Conclusion: For many women, seeking counsel from a regular gynecologic provider before seeking an abortion may not afford a significant benefit. However, some women express concerns with regard to seeking abortion counselling from their regular provider. These concerns underscore the need for gynecologic providers to foster patient–provider relationships that allow women to feel comfortable discussing all aspects of their reproductive health.

Nearly one-third of American women will have an abortion by age 45 (Jones & Kavanaugh, 2011). In 2011, specialized clinics accounted for 49% of abortion facilities and provided 94% of procedures; physician offices accounted for 17% of abortion facilities and provided 1% of procedures (Jones & Jerman, 2011). A mail survey conducted with a national probability sample of 1,800 practicing obstetrician-gynecologists (OB/GYNS) to assess the prevalence and correlates of abortion provision found that while 97% of respondents had met with patients seeking abortions, 14% actually provided the service (Stulberg, Dude, Dahlquist, & Curlin, 2011). The disparity between abortion prevalence and the number of providers offering this service reflects the current separation of abortion services from other aspects of reproductive health care in the United States.

The impact of this separation on the patient–provider relationship is understudied. In one survey of women obtaining an abortion, 17% of respondents felt their health care provider would treat them differently if they knew of their abortion (Shellenberg & Tsui, 2012). In a survey of 229 women presenting

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for abortion at one of two abortion clinics in New York and Chicago, Godfrey, Rubin, Smith, Khare, and Gold (2010) found that only 27% of women had seen their primary care provider regarding pregnancy decision making before their abortion. Women reported not seeing their primary care physician owing to fears of not being supported (23%), concerns for judgement (22%), and being sure of the decision (17%; Godfrey et al., 2010). Women who did see their primary care physician did so to seek advice or options counseling (46%), confirm a positive pregnancy test or seek a referral (42%; Godfrey et al., 2010). Although these quantitative data are limited in scope, they indicate that many women did not perceive their trusted providers to be a resource for nonjudgmental support in abortion decision making. This perception exists despite the fact that the vast majority of OB/GYNS report a willingness to help women obtain an abortion even if they have personal objections to abortion (Harris, Cooper, Rasinski, Curlin, & Lyerly, 2011). To elicit a deeper understanding of women's perspectives of the role that regular gynecologic providers play in abortion decision making, we sought to qualitatively explore women's experiences with patient–provider communication before obtaining their abortion at a dedicated abortion clinic.

Material and Methods

The data presented in this paper are a subanalysis of a qualitative study assessing the impact of doula support on women's first trimester surgical abortion experiences. Women were recruited from a high-volume, first-trimester surgical abortion clinic that offers doula support during the abortion procedure. This clinic is located within a large, public safety net hospital that serves a predominantly low-income population. The state in which the clinic is located has relatively few abortion restrictions; although it does have a parental notification law in place, the state does not have any state mandated counseling or waiting periods (Guttmacher Institute, 2015). Medicaid in this state pays for abortion in cases of rape, incest, and most medically indicated procedures.

After routine abortion counseling, a trained research assistant assessed eligibility and obtained consent to contact women for phone interviews within 2 weeks of the abortion. Inclusion criteria included: 1) age 18 years or older, 2) gestational age 13 6/7 weeks or less, 3) ability to understand the study and provide informed consent, and 4) English-speaking. A study team member used purposive sampling to invite a subset of women to participate in semistructured telephone interviews within the 2-week postabortion interval. Factors considered in sampling included: age, gestational age, presence or absence of a doula during the abortion, and abortion history. Oral consent was obtained before telephone interviews. Study participants were compensated with a $25 gift card. Institutional review boards at the John H. Stroger, Jr. Hospital and the University of Chicago approved the study.

After collecting demographic and reproductive health data, research staff trained in interviewing conducted 30- to 40-minute semistructured interviews addressing abortion decision-making, sources of emotional support, and experiences with doula support during abortion. This analysis focuses on women's responses to the questions: "*Do you have a doctor you see regularly for gynecological care, such as for contraception, talking about plans for pregnancy, other female health related issues? Did you speak with him/her about your decision to have an abortion?*" Interviews were digitally recorded, transcribed verbatim, verified for accuracy, and de-identified. Analysis involved a modified template approach, whereby the lead investigator developed an initial code dictionary reflecting emergent themes from the transcripts (Crabtree & Miller, 1999). The code directory was further modified with continued data review. The research team then met to discuss and resolve disagreements with code definitions. Two researchers independently coded five transcripts and achieved inter-rater reliability of 84.5%. Transcripts were coded and analyzed using Atlas.ti Version 7 (Berlin) to identify salient themes. The research team met to discuss and interpret key findings and resolve disagreements through discussion. This analysis presents salient themes regarding women's discussions with gynecologic care providers, including 1) reasons for not discussing abortion, 2) reasons for discussing abortion, and 3) factors contributing to the expectation that gynecologic care providers do not provide abortions.

Results

During the study period, we approached 191 women to obtain consent to be contacted for phone interviews. One hundred forty-four women provided consent to be contacted: 36 women declined to participate and 11 women did not meet eligibility criteria. Thirty women completed interviews, at which point interviews achieved thematic saturation. Only 8 of the 24 participants who had a regular gynecologic provider had communicated with their provider before their abortion. The remaining six women reported not having a regular gynecologic provider. Women ranged from 19 to 40 years of age, with a median age of 25 (Table 1). The majority of respondents were African American (96%) and single (80%). Most women had experienced a prior pregnancy, with a median of three pregnancies. One-half of participants had two or more children, and 19 had at least one prior abortion. Although we did not collect

Table 1
Sociodemographic and Obstetric History Factors for Study Participants

	Interview Participants ($n = 30$)
Age (y)	
18–25	18 (60)
26–35	10 (33.3)
≥36	2 (6.7)
Education	
≤High school	15 (50)
≥Some college	15 (50)
Gestational age (wk)	
≤ 9 0/7	17 (56.7)
9 1/7 to 13 6/7	13 (43.3)
Prior surgical abortion*	
Yes	20 (66.7)
No	10 (33.2)
Race/ethnicity	
African American	29 (96.7)
Hispanic/Latina	1 (3.3)
White	0 (0)
Other†	0 (0)
Gravidity, median (range)*	2 (1–10)
Parity, median (range)*	1 (0–7)
No. of prior induced abortion(s), median (range)*	2 (0–5)

Data are n (column %) unless otherwise specified.

* Data missing for the following: 16 for history of prior surgical abortion; 23 for gravidity; 1 for parity; 2 for prior induced abortions.

† Other includes Asian, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and Other.

measures of socioeconomic status for this study, the study setting is a public safety net hospital that provides care to a predominantly low-income population.

Reasons for Not Discussing Termination

Among the women who had a regular gynecologic provider but did not speak to their provider, the most salient themes regarding not discussing abortion decision making were 1) perceiving that the discussion would not be beneficial and 2) expecting that gynecologic care providers do not perform abortions. Other reasons women cited included 3) anticipating or experiencing logistical barriers and 4) worrying about disrupting the patient–provider relationship.

The majority of women expressed confidence in their decision to terminate the pregnancy. Frequently, women said they had nothing to discuss with their provider, because they were already resolved in their decision. As one woman stated: "If I had any thought about not doing [it] maybe I would have talked about it… but my mind was so set on doing what I did, that there wasn't nothing to talk about." Women also viewed the ability to diagnose their own pregnancy to mean that they did not need to see a provider. "I felt like I didn't need to. It was like, I took the home test or whatever." These statements highlight that with pregnancy, women have the ability to both diagnose and decide a course of management without medical advice.

Some women expressed that such discussions would be intrusive or potentially deleterious. One woman stated, "I wouldn't have discussed it with him [the doctor]…I made the decision to do what I did, it was… no one's business." Occasionally, women expressed concerns that the provider might attempt to change their minds. "I did not talk to [my doctor] at all because I just felt like… she might have persuaded me to keep the baby."

Women largely perceived that abortion was not within their regular gynecologic care provider's scope of practice. The presumption that women would not receive abortion-related care with their regular provider was often shaped by past experiences with an institution or specific provider's practices and values. Some women had seen their provider through prior pregnancies or other reproductive health experiences, but had never encountered abortion services at their provider's clinical setting. One woman articulated, "I never heard of [abortions] being done there. Every time I heard about it… they go and find out if they are pregnant… and then they go to… another hospital." Several women understood that abortion care was provided by a separate group of providers and not by their regular provider. One woman stated, "I didn't know that your own doctor can really be doing this stuff [abortion]," and another asserted, "My regular doctor is not an abortion doctor." However, many women stated they would have liked their regular provider to perform the procedure.

A subset of women visited their provider at religiously affiliated institutions and therefore anticipated that abortion services would not be offered. This expectation led most women not to request the procedure from their provider: "They don't do abortions at the clinic… that's a Catholic hospital. So they don't do abortions at all." Seeing their regular provider in a religiously affiliated clinic dissuaded some women from even speaking to their provider about abortion. One woman said, "when I did go to the hospital, it was a Catholic hospital…so it was like… I'm not gonna talk to them about it."

Many women did not schedule an appointment with their provider to avoid delaying the procedure. One woman explained, "I had already missed my appointment and … I didn't wanna, you know, wait no longer… the child was getting bigger in me… I just wanted to get it over with." Several women did not schedule an appointment with their regular provider, fearing that such appointments would not be timely. "I was just tryin' to find out quickly. I would have had to make an appointment with my doctor."

Additionally, some women were hesitant to discuss their decision with their regular gynecologic care provider, expecting their provider to pass judgment or express disappointment. One woman explained, "I had an ectopic pregnancy in November … they were very supportive. They were excited for me, so it's like, I feel like I'm disappointing them by telling them that I got an abortion." A small number of women with long-standing relationships wanted to protect their provider from emotional involvement in their decision. One participant said, "I recently know that she just had a baby… I think that that personally would have taken a toll on her." Another woman expressed reluctance to speak with her family's doctor, "… she's been knowin' me ever since I was a little girl… I think it would have been her feelings involved. And I didn't wanna, you know, put her through that."

Reasons for Discussing Abortion

Of the eight women who spoke with their gynecologic care provider, most had no reservations about disclosing their decision. However, fewer than one-half sought an appointment specifically to discuss the abortion or receive abortion-related care. Instead, most conversations occurred because the pregnancy was diagnosed or came up in discussion during previously scheduled appointments. "I talked to [my doctor] because I planned to come get a checkup anyway. I made an appointment to get my checkup and I talked to [him] about it." Another was prompted to speak with her gynecologist after a visit to the emergency room, "Like my ob/gyn, I had talked to her… She was like, 'You want to start your prenatal care?' I was like, 'No, because I already decided I'm not keeping it… The only reason that I've come to see you today is because when I had went to the emergency room, they had told me to schedule a follow-up visit with my OB-Gynecologist.'"

Women reported that providers were generally supportive of their decisions. Although few participants recalled receiving options counseling from their provider, four women reported receiving referrals for abortion-related clinical or financial services. "She didn't question my decision … she was supportive, and if I had any questions… she would answer it." Another woman reported, "When I found out that I was pregnant, the doctor… was asking if I wanted to keep it or not. And I told her no… And she gave me a list of clinics that I could go to." This provider also provided a list of financial resources. Another woman recounted, "[I asked] if my insurance would cover it. And he said that the insurance doesn't, but he did suggest that [the county hospital] has a very good program and… it's very inexpensive."

Barriers to Women Accessing Regular Gynecologic Care

Discussing the abortion was not an option for the six participants who did not have a provider. Several of these women received care at community clinics and did not have

relationships with a single provider. Others reported lapses in insurance as a reason for not having a gynecologic care provider. "I had a doctor's office, but I switched it, and I'm waiting for my new medical card to come." Aging out of pediatric care and insurance left a few women without a regular provider. "I don't have a doctor because… since I'm 19 now, I lost my doctor and my medical card." Several women regretted not having the opportunity to speak with their previous provider about their decision. One woman who had moved and not yet established care reflected that, "I would like ask about it, like how [having an abortion] would affect me like now and in the future."

Discussion

Abortion is largely separated from other aspects of reproductive health care provision. This study seeks to understand patient–provider communication about abortion. Specifically, this study evaluates women's decisions to communicate or not communicate with their regular gynecologic care providers before abortion. Few women sought their regular provider as a resource for pregnancy diagnosis, options counseling, or to obtain the abortion procedure. Two-thirds of women who had a regular gynecologic provider did not discuss their abortion decision with their provider. Many women were resolute in their decision and did not feel the need to speak to a trusted provider. Furthermore, women also viewed scheduling an appointment to discuss pregnancy options or abortion with a physician as an obstacle that would delay their care. These findings reflect the fact that, for many women, scheduling an appointment to seek guidance about abortion is unnecessary. Of the one-third of participants who did discuss their abortion decision with their physician, one-half reported a positive experience that resulted in useful referrals and guidance.

Women largely believed that their regular gynecologic care provider would not provide abortion-related care. It is not surprising that several women did not seek abortion-related counseling or care from religiously affiliated facilities, as more and more women receive their health care at such facilities. One in six patients in the United States receives care at a Catholic Hospital (Catholic Health Association of the United States, 2015). Additionally, many participants who believed that their physician would not perform their abortion were likely correct, because only 14% of OB/GYNS perform abortions (Stulberg et al., 2011). However, this finding also signifies that some women do not view their regular gynecologic provider even as a resource for abortion-related counseling. A gap, therefore, exists between this perception and the reality that the vast majority of OB/GYNS are willing to provide abortion counseling and referrals, even if they morally disagree with abortion (Harris et al., 2011). These findings underscore the need for gynecologic care providers to take greater care to convey their openness to discussing abortion with their patients.

A number of participants were reluctant to speak to their regular provider owing to concerns about 1) keeping the matter "private," 2) avoiding being dissuaded by the provider, 3) maintaining the patient–provider relationship, and 4) shielding the provider from involvement in the decision. That some women felt the need to protect their physician from their abortion decision may indicate that these women are projecting their discomfort with this decision. Alternatively, physicians may have conveyed their discomfort with abortion to their patients. This discomfort in speaking to providers about abortion and apprehension about being judged for their decision illustrates the intrusion of abortion stigma into the patient–provider relationship. Abortion stigma has been defined as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (Kumar, Hessini, & Mitchell, 2009). The reluctance of some women to discuss their abortion decision making with their regular provider reflects what has been termed the abortion "prevalence paradox"—despite the high prevalence of abortion, women who have abortions anticipate stigmatization and subsequently choose not to disclose their abortions. Nondisclosure, in turn, results in the perception that abortion is uncommon and perpetuates discrimination against women who have abortions (Kumar et al., 2009).

This study has a number of limitations. Although we elicited important themes relating to patient–provider communication about abortion, qualitative research is predominantly hypothesis generating and cannot describe the prevalence of these findings among women seeking abortion. Furthermore, this study provides women's perspectives on patient–provider communication about abortion, but does not give providers' perspectives on such discussions. Additionally, the sample was homogeneous and findings may not be generalizable to all clinical settings. Our study's participants were primarily low-income women of color, thereby reflecting a large segment of abortion patients (Finer & Zolna, 2014; Jones & Kavanaugh, 2011). However, the experiences of women represented in this study may not reflect the experiences of women from other socioeconomic or racial/ethnic backgrounds. Finally, this study was conducted in an abortion clinic that only provides first trimester abortion services with women who obtained surgical abortion. Therefore, we were unable to elicit the perspectives of women seeking second trimester abortion services or women who had obtained medication abortions. It is possible that women presenting for these procedures had different experiences with regard to pre-abortion communication with a regular provider.

Implications for Policy and/or Practice

This study demonstrates that women who obtained an abortion at a dedicated abortion clinic did not regard their regular gynecologic provider as a resource for abortion decision making. Participants primarily sought and successfully obtained abortion care independent of their regular gynecologic provider. For many women, therefore, seeking counsel from their regular provider may not afford a significant benefit. However, some participants voiced concerns about speaking to their regular gynecologic provider about their abortion decision. In a prior study assessing women's preferences for abortion care, nearly 40% of women preferred to obtain their abortion in a dedicated abortion clinic rather than with a regular provider, because of concerns of privacy, anonymity, judgment, and wanting to keep the procedure separate (Godfrey et al., 2010). Therefore, gynecologic providers may not be adequately conveying to women that they can be trusted to provide nonjudgmental guidance and care for the full spectrum of women's reproductive health experiences. By not fostering patient–provider relationships that allow women to feel comfortable discussing all aspects of their reproductive health, gynecologic providers risk undermining the exchange of important health information and the provision of optimal reproductive health care. Therefore, gynecologic providers should seek to normalize discussions of abortion during routine gynecologic visits to ensure that, when faced with such

decisions, women who so desire feel that they can turn to their provider for guidance in abortion decision making.

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