Women's Satisfaction With Abortion Care in Academic Family Medicine Centers

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BACKGROUND AND OBJECTIVES: The primary study aim was to describe patient satisfaction regarding abortion experiences in urban academic family medicine centers (FMCs).

METHODS: We conducted a cross-sectional survey of 210 women obtaining a first trimester medication or aspiration abortion at four FMCs. The 32-item written survey consisted of multiple choice, open-ended questions and Likert scale measures (for satisfaction: 1=very dissatisfied, 2=somewhat dissatisfied, 3=somewhat satisfied, 4=very satisfied, for quality of care: 1=poor, 2=average, 3=good, 4=excellent). We used Fisher's exact test to examine bivariate relationships. Responses to open-ended questions were coded and categorized.

RESULTS: The majority of women (93%) were very satisfied with their abortion experience in their FMC, regardless of clinical site or abortion method. Mean scores for the quality of the staff, doctor, abortion counseling, and contraceptive counseling were all at least 3.9 (out of 4). Women most commonly cited positive interactions with the staff and physicians as the best part of their experience.

CONCLUSIONS: This study demonstrates that women who receive abortion services at academic FMCs are highly satisfied with their care.

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Abortion access has become increasingly restricted in certain regions of the United States, and 87% of US counties are without an abortion provider.[1] Family physicians, who are more likely to practice in rural areas and are required to train in office-based gynecological skills[2] are well positioned to provide abortion services in shortage areas. First trimester medication and aspiration abortion can be safely and effectively performed in family medicine offices.[3-5] Little research has been done to describe the patient's perspective of the advantages and disadvantages of obtaining abortion services in primary care. Prior studies have reported that many women in urban communities theoretically would prefer to have an abortion in a primary care office.[6,7] To our knowledge, no study has documented the experiences of women who have actually received abortion services in an urban primary care office setting. To address this gap in the literature, we conducted cross-sectional surveys of women receiving first trimester abortion services at four urban academic family medicine centers (FMCs). The study aim was to describe women's abortion experiences in academic family medicine, including satisfaction, perceived quality of care, and preferences for care. An exploratory aim was to compare women's experiences obtaining abortions in family medicine with any prior abortion(s) obtained in a non-primary care setting (eg, abortion clinic, family planning clinic, hospital).

Methods

Study Sites

From April 2009–August 2010, we conducted a survey of women obtaining abortions at four urban academic

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FMCs: Site #1 in New Brunswick, NJ; Site #2 in New York, NY; Site #3 in Bronx, NY; and Site #4 in Chicago, IL. All study sites are affiliated with family medicine residencies and offer "opt-out" abortion training (eg, residents train in abortion unless they explicitly decline training). Site #4 is located in a state in which Medicaid funding for abortion is restricted to cases of rape, incest, and circumstances that threaten the life of the woman; the other study sites are located in states in which Medicaid funds abortion using broadly defined criteria (eg, includes psychological well-being). At the time of the study, none of the sites were in states with restrictive abortion laws such as parental consent or 24-hour mandatory waiting periods. All sites offer medication and aspiration abortion up to 9.0 weeks gestational age. For pain control, all sites offer local analgesia/anesthesia only—oral non-steroidal anti-inflammatory (NSAID) medications and oral narcotics for medication abortion, and oral NSAIDs and a paracervical block for aspiration abortion. Depending on the site, the abortion volume at the study sites ranges from approximately 35–150 cases/year provided by two to five attending physicians who also supervise resident physicians. We obtained Institutional Review Board approval at all clinical sites.

Eligibility and Enrollment

All participants were English or Spanish-speaking women, at least 15 years old, and requesting elective abortion services. Women were recruited in consecutive fashion after abortion care was rendered, which was immediately after the aspiration abortion or at the 1–2 week follow-up visit for medication abortion. Study participants were given incentives of $20 gift cards. Given the sensitive nature of the study topic, we obtained a waiver of signed consent and provided a cover letter explaining the right to decline enrollment and assurance that clinical care would not be affected by one's decision to participate. To minimize any perceived coercion to participate or bias toward providing socially desirable responses, women were approached about the study at the end of the abortion visit. The surveys contained no personal identifiers, and participants sealed their surveys in opaque envelopes prior to returning them to research staff.

Survey Instrument

We designed a self-administered, 32-item written survey that was translated to Spanish and back-translated to English to assess content validity. We pilot-tested the English and Spanish versions of the survey on 40 women for readability and face validity. Women self-reported their age, race/ethnicity, education level, marital status, pregnancy history, religious affiliation, whether she was an established patient (defined as receiving care at that FMC at least once in the past), how she paid for the abortion, and reasons why she selected the FMC for abortion care. Overall satisfaction with the visit was assessed using a 4-point Likert scale (1=very dissatisfied, 2=somewhat dissatisfied, 3=somewhat satisfied, 4=very satisfied). Women rated the quality of the staff, clinician, abortion counseling, and contraceptive counseling via a 4-point scale (1=poor, 2=average, 3=good, 4=excellent). The physician who performed the abortion documented the gestational age, other health services rendered, and whether the woman was a "continuity patient" of the physician who performed the abortion (defined as someone whom the physician had cared for at least once prior). Women answered open-ended questions to elicit positive or negative aspects of their abortion experience (eg, "What did you like least/most about getting an abortion at this office?" and "If you could change anything about your abortion experience at this office, what would that be?"). Abortion pain was assessed with an 11-point numerical visual analog scale (0=no pain, 10=worst pain possible), which has been validated in studies measuring abortion pain.[8-12]

Statistical Analysis

We used SAS Version 9.1 (SAS Institute, Cary, NC) for all analyses. After performing descriptive statistics, we used Fisher's exact test to assess bivariate relationships.[13] Among the subset of women whose most recent prior abortion was obtained in a non-primary care setting, we used Wilcoxon's test to compare satisfaction with that experience with their present abortion experience at the FMC.[14] We set α at 5%. Due to limited missing data, we computed percentages and statistics on non-missing data. We reviewed groups of hand-written responses to each question and assigned codes to each response based on a consensus-coding scheme. We then reviewed codes across all questions, reassigning responses, redefining or combining codes as necessary based on recurring patterns. The majority of responses were assigned one code only; lengthier responses were assigned more than one code depending on the content.

Sample Size

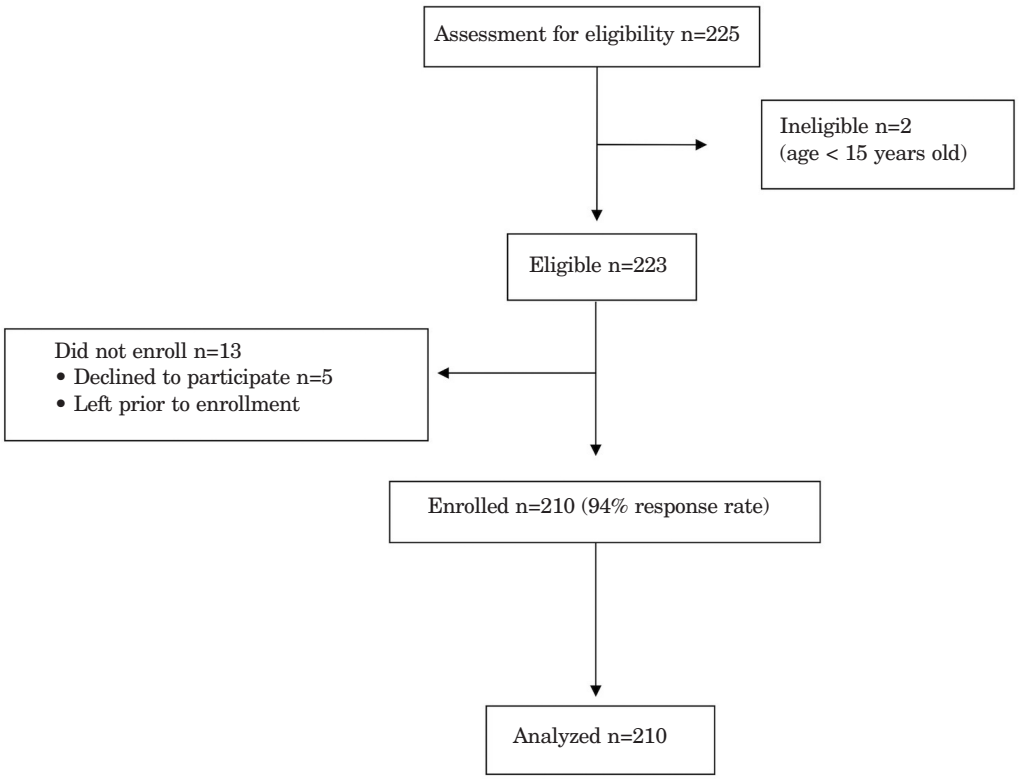
Among women who reported a previous abortion at a non-primary care setting, a sample size of 56 was necessary to detect a difference of 10% between satisfaction scores via a 4-point Likert scale (comparing this index abortion to the prior abortion) assuming an average satisfaction score of 3.4 ± 0.9 SD,[15] α=0.05 and β=0.80. We recruited 200 women in the overall sample in order to approximate the target sample size for this subgroup (n=54).

Results

Enrollment (Figure 1) and Demographics (Table 1)

We screened 225 women, of which 223 were eligible. Of the 223 eligible women, 210 enrolled in the study (94% response rate). The study participants comprised a diverse racial and ethnic group: 19% white, 36% non-Hispanic African American,

Figure 1: Enrollment Flow Diagram



24% Hispanic/Latina, 10% Asian Pacific Islander, and 13% other. Approximately half of women were nulliparous (58%), and 40% reported a previous abortion.

Abortion Visit Details and Patient Satisfaction (Table 2)

The mean gestational age at the time of the abortion was 6.6 weeks (SD ± 1.3 weeks). Medication abortions comprised 56% of all abortions; the remaining 46% were aspiration abortions. Reported pain scores associated with medication abortions did not significantly differ from those associated with aspiration abortion. The most common reasons women selected the FMC for abortion care were: "I am/was a patient here" (55% of responses), "I was referred by my doctor" (30% of responses), and "referred by someone else" (18% of responses). Fifty-six percent of participants reported being seen at that office at least once in the past. Physicians identified nearly one-third of patients as continuity patients (defined as being a patient they had cared for at least once prior). Almost all visits (96%) included family planning services. For 14% of all abortion visits, physicians also provided care for other conditions such as depression, hypertension, breast cancer screening, and asthma.

The vast majority of women (93%) were "very satisfied" with the overall abortion experience. Women reported mean quality of care scores of 3.9 (out of 4) or higher for the staff, doctor, abortion, and contraceptive counseling. There were no differences in satisfaction or perceived quality of care scores based on race/ethnicity, abortion method chosen (aspiration or medication), or study site (results not shown). Among the subset of 54 women who reported that their last abortion was at a non-primary care site, women reported a lower mean satisfaction score with that experience compared with this index abortion at the FMC (non-primary care site=3.0 ± 1.0 SD, FMC=3.9 ± 0.14 SD respectively, $P<.01$, results not shown). The mean pain score for the index abortion at the FMC (5.48 ± SD 2.74) did not differ significantly from the mean pain score (5.36 ± SD 2.89) reported for the prior abortion (results not shown).

Semi-Qualitative Responses (Tables 3 and 4)

In response to the questions "What did you like least about your abortion experience here?" and "If you could change anything about your abortion experience at this office, what would that be?" the most common response to these two questions was that "nothing" (169/299 responses, 56.5%) needed to be changed or was negative about the experience

Table 1: Demographics

	Total n=210	Site 1 n=39	Site 2 n=38	Site 3 n=94	Site 4 n=39
Mean age (SD)	26.2 (6.4)	27.2 (6.4)	25.9 (7.2)	25.5 (6.3	27 (6.1)
Race/ethnicity*	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**
White	37 (19)	14 (36)	1 (3)	18 (21)	4 (10)
African American	71 (36)	11 (28)	17 (47)	26 (30)	17 (44)
Hispanic/Latina	48 (24)	6 (15)	16 (44)	22 (26)	4 (10)
Asian Pacific Islander	19 (10)	4 (10)	0 (0)	5 (6)	10 (26)
Other	25 (13)	4 (10)	2 (6)	15 (17)	4 (11)
Education**					
Less than high school	12 (6)	0 (0)	8 (21)	4 (4)	0 (0)
High school	46 (22)	5 (13)	16 (42)	23 (25)	2 (5)
Some college or more	149 (72)	33 (87)	14 (37)	65 (71)	37 (95)
Marital status***					
Single	35 (17)	4 (10)	8 (21)	22 (25)	1 (3)
Has partner but not married	138 (67)	28 (72)	23 (59)	58 (66)	29 (73)
Married	32 (16)	7 (18)	7 (18)	8 (9)	10 (25)
Religious affiliation*					
Catholic	70 (35)	11 (28)	17 (47)	34 (39)	8 (21)
Christian/Protestant	60 (30)	14 (36)	8 (22)	23 (28)	14 (37)
None	41 (21)	7 (18)	10 (28)	16 (18)	8 (21)
Muslim	12 (6)	3 (8)	1 (3)	4 (5)	4 (11)
Jewish	2 (1)	1 (3)	0 (0)	1 (1)	0 (0)
Payment for abortion***					
Private insurance	90 (44)	24 (63)	9 (24)	33 (36)	24 (63)
Medicaid	76 (37)	6 (16)	25 (66)	43 (47)	2 (5)
Cash	20 (10)	4 (11)	4 (11)	8 (9)	4 (11)
Other	19 (9)	4 (11)	0 (0)	7 (8)	8 (21)
Nulliparous******	117 (58)	25 (64)	17 (47)	50 (57)	25 (64)
Had prior abortion*******	80 (40)	10 (26)	18 (49)	38 (44)	14 (36)

Missing data: * n=200, ** n=207, *** n=205, ****n=201, ***** n=202
SD—standard deviation

(Table 3). The second most common response was related to abortion pain (13.4%), with recognition by some that pain was an expected part of the process. ("The procedure itself was uncomfortable, but that is the case anywhere probably.") Logistical issues such as a long wait and suggestions for improving the physical office space ("larger exam room") comprised 11.7% of responses. Although not directly related to the office experience, 7.7% of responses were variations of the sentiment that women wished they "did not have to have an abortion at all." A small minority of responses (3%) reflected a desire for moderate sedation as an option for abortion procedures.

Table 4 summarizes 426 combined responses to the questions, "What did you like most (if anything) about your abortion experience here?" and "If you would choose to come back here for an abortion, please explain why." The most common response (39.7%) was related to positive interactions with the physician and staff ("The doctors/nurses were very friendly and professional"), followed by feeling "comfortable" (10.8%) and "familiar" with the doctor and/or office (9.6%). Women also valued the privacy and confidentiality offered by obtaining an abortion in a primary care setting (6.8%) and the quality of information provided during their visit (6.6%). The remaining categories comprised less

Table 2: Abortion Visit Details and Satisfaction Scores

	Total n=210
Mean gestational age in weeks (SD)	6.6 (1.3)
Abortion type[a]	**n (%)**
Medication abortion	116 (56)
Aspiration abortion	90 (44)
Pain scores (0–10 scale, 0=no pain, 10=worst pain possible)	**Mean (± SD)**
All abortions combined	6.0 (2.8)
Medication abortions only	6.0 (3.0)
Aspiration abortion only	6.0 (2.5)
Reason why woman chose this site*	**n (%)**
I am/was a patient here	115 (55)
I was referred by my doctor	62 (30)
I was referred by someone else	38 (18)
I would rather come to a family medicine office	31 (15)
The office gave me the earliest appointment	24 (11)
The office is closest to home	15 (7)
This office was cheapest	11 (5)
Other	19 (9)
Continuity of care and other services rendered	
Woman is established patient at this site**	117 (56)
Physician identified woman as a continuity patient†	58 (29)
Post-abortion contraception plan made	193 (96)
Screening for sexually transmitted infections (STI)	52 (26)
Other gynecologic services (excluding STI screening)	30 (15)
Non-gynecologic services	29 (14)
Satisfaction with overall abortion experience in this office[b]	
Very satisfied	195 (93)
Somewhat satisfied	13 (6)
Somewhat dissatisfied	1 (0.5)
Very dissatisfied	0 (0)
Perceived quality of care with:	**Mean (SD)**
Staff	3.9 (0.3)
Doctor	4.0 (0.2)
Abortion counseling	3.9 (0.4)
Contraceptive counseling	3.9 (0.4)

Missing data: [a] n=206, [b] n=209; satisfaction scores assessed via 4-point Likert scale (1=very dissatisfied, 2=somewhat dissatisfied, 3=somewhat satisfied, 4=very satisfied); quality of care scores assessed via 4-point scale (1=poor, 2=average, 3=good, 4=excellent)
* More than one response could be chosen
** Based on patient-reported data: "Have you ever been to this office as a patient in the past (before this abortion)?"
† Based on physician-reported data: "Have you cared for this patient at least once before this abortion visit?"
SD—standard deviation

Table 3: Combined Responses to the Questions, "What Did You Like Least About Getting an Abortion at This Office?" and "If You Could Change Anything About Your Abortion Experience at This Office, What Would That Be?"

Codes n=299 responses	n (%)	Examples of Comments
Nothing	169 (56.5)	"Nothing." "Nothing, everything was good."
Pain and discomfort	40 (13.4)	"The procedure itself was painful at first." "The procedure itself was uncomfortable, but that is the case anywhere probably."
Logistics and physical office space	35 (11.7)	"The very long wait." "Put some nice things on the ceiling to look at." "Larger exam room."
Personal feelings/conflict about abortion	23 (7.7)	"The mere fact that I was having an abortion." "Admitting to myself that I needed it [the abortion]."
Would have liked sedation option	9 (3.0)	"Give the option of going to sleep." "Staying awake, but it wasn't that bad at all."
Concerns about privacy	8 (2.7)	"I didn't like being asked by anyone other than Dr why was I here." "Others coming in and discussing other matters with nurse or assistant."
Abortion method choice	6 (2.0)	"Probably would have chosen the suction. Much quicker probably less bleeding and cramping than pill abortion." "I would have taken the pill."
Counseling	5 (1.7)	"Talking to two counselors, one would have been OK." "No counselor was available but the packet was helpful."
Feeling scared	4 (1.3)	"It was my first and only abortion and my first visit here. I didn't know what to expect." "I was a little scared before I saw the doctor."
Total	299 (100)	

than 6% of responses each: logistical issues, reputation, "pleasant office," feeling safe and secure, trust, office is not an abortion clinic, office can provide continuity of care, and receiving non-judgmental care.

Discussion

To our knowledge, this study is the first to document patient satisfaction after receiving abortion services in an academic urban family medicine setting. This ethnically and racially diverse group reported high satisfaction with their abortion experience, regardless of the abortion method chosen. The relative proportion of medication abortions (56%) was higher than the national average reported during the study period (22% of all abortions that occur before 9 weeks gestation)[16] but relatively similar to the national average for offices with small annual caseloads (46% of all abortions).[16] This finding may reflect increased comfort and familiarity among providers and patients with medication abortion in the primary care setting, as reported previously.[17,18]

This study builds directly on the work of prior surveys asking women to theoretically consider the relative benefits and disadvantages of obtaining abortion services in primary care, whether from their primary care provider (PCP) or at their primary care office.[6,7,17,19] In prior studies, the proportion of women who hypothetically reported a preference for obtaining abortion services in primary care was 20%–67%;[7,17,19] this wide range is likely secondary to the lack of a standardized survey and variations in study setting and patient population. Our study found that 93% of women were very satisfied with their experience. This high level of patient satisfaction is similar to that documented in prior studies among women obtaining abortions in specialized abortion clinics[20,21] and studies comparing satisfaction with different abortion methods (eg, aspiration abortion versus medication abortion).[15,22] This growing body of literature regarding abortion preferences provides reassurance that, collectively, women are generally satisfied with their abortion experience, regardless of the clinical setting or abortion method chosen.

In previous studies, women most commonly reported that "comfort" and "familiarity" with their doctor or the office as reasons why women would theoretically choose to have an abortion at a FMC office.[7,17] While "comfort" and "familiarity" were also important to women in this study, women most often cited positive patient-staff interactions (eg, warm, friendly, and professional) as the best aspect of their experience and a reason why they would return to

Table 4: Combined Responses to "What Did You Like Most About Your Abortion Experience Here?" and "Reasons Why I Would Come Back"

Codes n=426 responses	n (%)	Examples of Comments
Positive attributes of staff and clinician	169 (39.7)	"Doctor was really concerned about me and my choice." "Doctors/nurses were very friendly and professional."
Felt comfortable	46 (10.8)	"The Dr and RN made me feel comfortable as possible. They explained everything step by step."
Familiarity	41 (9.6)	"Because my doctor is a part of this practice." "I already know the place and the staff."
Private and confidential	29 (6.8)	"Not everyone knew the reason why I was here." "More privacy in regards to the reason for my visit."
Good information provided	28 (6.6)	"Very informative." "The explanation was thorough. All questions answered."
Logistical issues	23 (5.4)	"It is much closer to my home." "Because free/cheap for students."
Quality of service/reputation	17 (4)	"I really just like the care. I know I'm in great hands." "Family atmosphere, reputable location."
Procedure went well	16 (3.8)	"Get done in a few minute (sic)." "It was fast and simple."
Office environment	11 (2.6)	"It is a clean office and the people were nice." "Because it's [a] nice environment."
Felt safe and secure	11 (2.6)	"Its my doctor and I feel safe." "Because I feel more secure here."
Not an abortion clinic	10 (2.3)	"This was an actual office not an abortion clinic."
Family medicine office/continuity of care	9 (2.1)	"Family centered, more appropriate." "I could come here for more health issues."
Trust	8 (1.9)	"Trust this office more." "I trust my family doctor."
Nonjudgmental	8 (1.9)	"I didn't feel like I was being judged." "Very friendly and non-judgmental."
Total	426 (100)	

the FMC for an abortion if necessary. The strong, positive association between patient-centered care and satisfaction has been similarly demonstrated in family planning clinics,[23] underscoring the importance of patient-centered counseling and positive staff-patient interactions whether in primary care or specialized clinical settings.

Continuity of care or the ability to receive care for other medical issues was mentioned infrequently (2.6% of all responses) as an advantage to seeking abortion care at an FMC. Further, almost half of women identified themselves as new patients to the practice, reflecting the fact that many selected the FMC based on a referral from others. These data highlight the potential of FMCs to expand abortion access not only to their own continuity patients but also for women in the larger community. While continuity of care may not have been a high priority for women when making the initial appointment, physicians ended up providing care for acute and/or chronic medical problems during one out of every six abortion visits (15%). This underscores the fact that the integration of abortion services in family medicine provides windows of opportunities to address preventive health and other medical issues.

Women have cited privacy and anonymity as reasons to both seek care and not seek care from their primary care site/provider for abortion services.[7,17,19] These mixed findings likely represent different conceptualizations of privacy and anonymity and may also reflect geographic location. In our study, women felt that the FMC offered privacy and anonymity because the nature of their visit was not obvious, and they could not be identified as an "abortion patient" among others in the waiting room. In contrast, women surveyed in family planning clinics who preferred not to obtain abortion care from their PCP defined privacy as being able to obtain abortion care from a team of providers with whom they have no established relationship.[19] Reasons for this preference included "physician knows the patient's family" and "fear of being

judged."[19] Regardless of how these constructs are applied, privacy and anonymity are important to women seeking abortions, and fears of disclosure are strongly rooted in the pervasive stigmata associated with abortion in the United States and worldwide.[24]

A minority of women cited pain as a negative factor associated with their experience, and very few stated they would have preferred to have the option for intravenous sedation. Women who had had abortions in a non-primary care setting did not report pain scores that were significantly different than the pain associated with the index abortion at the FMC. A qualitative study among women obtaining abortions in a Northeastern family planning clinic also reported that pain control options were not of primary concern when deciding where to get an abortion.[25] These findings support the feasibility of offering abortion in settings that do not have the capacity to provide intravenous sedation and are particularly relevant in light of the fact that two thirds of US abortion providers offer local anesthesia only.[26]

The group of women who had had prior abortions in a non-primary care setting reported higher satisfaction with their current experience at FMC. While these reports are subject to selection and recall bias, potential reasons behind this finding should be explored given its health service and public policy implications. For some women, being able to avoid anticipated fears associated with an abortion clinic was a distinct advantage of seeking care at a FMC ("I wanted a pleasant environment and not have to face protestors"). Procedures designed to protect patient privacy and promote safety in abortion clinics (eg, security systems, bullet-proof windows) have been reported to heighten feelings of fear, shame, and isolation among patients.[27] At the FMC study sites, the absence of such "visible" safety precautions and the presence of other patients seeking care for "routine" problems may help normalize the abortion process and lead to increased satisfaction. Providing abortion services in primary care, as well as providing primary care in family planning or abortion clinics, are two complementary strategies that could destigmatize the abortion experience for women.

There are several limitations to this study. Because this was a convenience sample, our results may not be representative of all women who seek abortions in our offices. However, we believe that our results are reflective of the overall experiences of our patients given the high response rate (94%). Our findings are not generalizable to non-academic settings or rural areas of the United States, particularly states with more restrictive abortion laws and greater anti-abortion sentiment in the community. As with prior studies regarding abortion preferences,[6,17,19] responses regarding women's comparisons of prior abortion experiences in non-primary care settings with their experience in the FMC may be subject to selection bias, recall bias, and an over-reporting of socially desirable responses. It is also possible that our quality of care ratings were biased toward higher scores because the scale contained two positive responses and only one negative response (1=poor, 2=average, 3=good, 4=excellent).

Our study is the first to demonstrate that women are highly satisfied with their abortion care in urban academic family medicine centers. These FMCs provided services for their established patients and served as a referral site for women from the community. These findings support the need for continued training in abortion among family physicians and the continued integration of abortion care services with primary care services. Future research is necessary to describe and compare women's experiences in other family medicine settings, including non-academic sites, in rural settings, and in areas with abortion provider shortages.

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Conflicts of interest: Dr Wu is a Nexplanon® trainer for Merck.

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