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Original research article

Influence of clinician referral on Nebraska women's decision-to-abortion time☆,☆☆

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Abstract

Objective: To assess the association of clinician referral with decision-to-abortion time.
Study design: We conducted a cross-sectional survey of women seeking abortion at all three Nebraska abortion clinics. We defined referral as direct (information for an abortion clinic), inappropriate (information for a clinic that does not provide abortions) or no referral. Women reported when they recognized their pregnancy, decided to seek abortion and contacted a clinician. The primary outcome — decision-to-abortion time — was time from certain decision to abortion. We used multivariate linear regression analysis, controlling for potential confounders.
Results: Participants (n=356) were a mean of 26.8±5.3 years old, primarily white (62%), unmarried (88%) and urban (87%), with a mean gestational duration of $8^{2/7}$ weeks (S.D.±20 days). Forty-six percent (164) had contacted a clinician and 30% (104) had discussed abortion with one before their abortion. Of those, 30% received a direct referral, 6% received an inappropriate referral and 64% received no referral. Decision-to-abortion time did not vary by referral type [mean difference compared with direct referral: inappropriate referral, 1.1 days, 95% confidence interval (CI) −13.4 to 15.6, p=.88; no referral, −0.4 days, 95% CI −7.0 to 6.3]. The most common reasons cited for delay in obtaining an abortion were an inability to get an earlier appointment (105/263, 40%) and time needed to raise money to pay for the abortion (73/263, 28%).
Conclusion: While neither occurrence of referral nor type was associated with decision-to-abortion times, women in Nebraska continue to face barriers to timely abortion care.
Implications: Additional research is needed to explore whether quality clinician referral improves abortion access and whether increased resources should be dedicated to improving referral patterns.

Keywords: Abortion; Referral; Abortion referral; Access; Delay

1. Introduction

Despite its being a common procedure, 58% of women who have abortions wish that they could have obtained their abortion sooner [1]. Difficulties finding an abortion provider, distance from the clinic and referral to another clinic (both clinics that do and do not provide abortions) have been identified as logistical factors contributing to delays in obtaining an abortion [2]. Abortion-related complications increase with advancing gestational age [3,4]. The cost of the abortion, access to services and women's stress also

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increases after the first trimester. Consequently, efforts to decrease delay in accessing abortion are critical.

Nebraska has many state abortion restrictions, including a 24-h waiting period, restrictions on abortion insurance coverage and prohibition of telemedicine for abortion provision [5]. Nebraska has five abortion providers, three of which are located in clinics [6]. Crisis pregnancy centers — nonprofit organizations offering free services to pregnant women, including pregnancy tests, counseling and ultrasounds — are increasingly present across the country, including Nebraska [7].

A recent commentary on referral making in the current landscape of targeted abortion regulations identified abortion referral as an overlooked and potentially critical component of access to abortion [8]. Women seeking abortion may request referrals, but one study found that less than half of phone calls resulted in a direct referral to an abortion clinic even after prompting staff members [9]. In a recent Canadian study, delays in obtaining abortion referrals were more common in women presenting after 10 weeks of gestation compared with those presenting before 10 weeks [10].

The paucity of abortion providers and abundance of restrictions may contribute to delay women seeking abortion experience in Nebraska. Appropriate clinician referral may expedite the time women need to navigate the logistic barriers in finding an abortion provider. We assessed the association of clinician referral with delay in women obtaining abortion in Nebraska. We hypothesized that women who received a direct referral to an abortion clinic would access abortion more quickly than women who did not.

2. Materials and methods

Between July 2014 and January 2015, English-speaking women aged 19 years and older presenting for an abortion for all indications at the three abortion clinics in Nebraska were recruited for this cross-sectional survey. Although women age 18 years may consent for an abortion without parental involvement, we included women at least 19 years old — Nebraska's legal age of consent — because they could consent for the study. We excluded women if it was not feasible to enroll them for logistical reasons (e.g., clinic's schedule was behind and enrollment would disrupt clinic flow). After completing data collection, we excluded five women with fetal anomalies because these women presented later in pregnancy after a different referral pattern. The institutional review boards at the University of California, San Francisco, and the University of Nebraska Medical Center approved this study.

Research staff obtained verbal informed consent and administered the electronic survey, directly inputting participant responses into a computer database. Participants were enrolled after ultrasound evaluation but before the abortion. The survey was modeled after previous studies in consultation with researchers in abortion delay [1,2]. The majority of the survey asked about the timing of steps in obtaining an abortion and the participant's interactions with clinicians. We defined clinician as any person the participant identified as providing healthcare and with whom she discussed the pregnancy. This included but was not limited to physicians, nurse practitioners, emergency department providers, primary care providers and crisis pregnancy center workers. For simplicity, we refer to these providers as "previous clinicians" from here on. With calendar assistance, women reported seven dates before the abortion: (1) first day of last menstrual period, (2) first suspicion of pregnancy, (3) first pregnancy test, (4) first consideration of abortion, (5) certainty of abortion decision, (6) first contact with a clinician and (7) first call to the abortion clinic. The survey date was recorded as the date of the abortion. We asked participants about all clinicians contacted before the date of abortion, whether or not they discussed abortion with the clinician and how the provider responded when abortion was discussed. Women indicated how challenging they thought it was for women in Nebraska to obtain an abortion on an electronic visual analogue scale of 0–100 (0 "not challenging" to 100 "extremely challenging"). We also collected demographic information, desire for earlier abortion, reasons for delay and ways that women located the abortion clinic. All participants received a US$20 gift card.

We categorized our primary predictor — clinician referral — as direct (information given for a clinic that provides abortions), inappropriate (information given for a clinic that does not provide abortions) or no referral [9]. Women receiving referrals from more than one clinician were categorized as (1) inappropriate if any contacted clinicians provided an inappropriate referral and the other clinicians provided no referral, (2) direct if any contacted clinicians provided a direct referral and the other clinicians provided no referral and (3) no referral if all contacted clinicians did not provide a referral. No women received both a direct referral and an inappropriate referral. The lead author coded all referrals. We defined the primary outcome — decision-to-abortion time — as the time from certainty of abortion decision date to scheduled abortion date.

From previous studies, we anticipated that 11% of women would contact a clinician before their abortion and 46% of those women would receive a direct referral (5.1% of the study population) [1,9]. To have 80% power, assuming an alpha of 0.05 and a beta of 0.20, to detect an effect size of 7 days with a standard deviation of 7 days for the primary outcome, we calculated a sample size of 16 women who received a direct referral (of 309 women total) and 18 women who did not. We performed an interim analysis at 4 months to evaluate the actual proportion of women who contacted a clinician before their abortion. That analysis showed only 9 out of 203 women enrolled (4.4% of the study population) had received a direct referral; we therefore increased our sample size to 361 women.