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A good abortion experience: A qualitative exploration of women's needs and preferences in clinical care

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ABSTRACT

What do women ending their pregnancies want and need to have a good clinical abortion experience? Since birth experiences are better studied, birth stories are more readily shared and many women who have had an abortion have also given birth, we sought to compare women's needs and preferences in abortion to those in birth. We conducted semi-structured intensive interviews with women who had both experiences in the United States and analyzed their intrapartum and abortion care narratives using grounded theory, identifying needs and preferences in abortion that were distinct from birth. Based on interviews with twenty women, three themes emerged: to be affirmed as moral decision-makers, to be able to determine their degree of awareness during the abortion, and to have care provided in a discreet manner to avoid being judged by others for having an abortion. These findings suggest that some women have distinctive emotional needs and preferences during abortion care, likely due to different circumstances and sociopolitical context of abortion. Tailoring services and responding to individual needs may contribute to a good abortion experience.

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1. Introduction

Many women experience both abortion and birth over the course of their reproductive lives. In the United States, an estimated 30% of women have an induced abortion by age 45 (Jones and Kavanaugh, 2011) and of those women who have had an abortion, 59% have previously given birth (Jerman et al., 2016). Abortion represents a transition for pregnant women, moving from the possibility of bearing that child to proceeding with one's life as is. As with birth, how abortion happens matters to women, their families and communities (Lie et al., 2008; Lyerly, 2013; Simkin, 1991). However, unlike with birth, researchers and policy makers have given less attention to what constitutes a good abortion experience. This reality may be due to a greater focus on defending access to abortion by creating a body of evidence demonstrating that it does not harm women physically or mentally and improving its technical aspects. Fortunately, undergoing an abortion in the U.S. is extremely safe (Biggs et al., 2017; Jatlaoui et al., 2016) and the process is effective (Ireland et al., 2015), permitting a shift in focus to improving other aspects of care quality, namely patient-centeredness, which encompasses care guided by a patient's values (Institute of Medicine, 2001). Prior studies suggest that most women tend to be satisfied with their care (Taylor et al., 2013; Tilles et al., 2016) but some women have challenging experiences (Kimport et al., 2012; Weitz and Cockrill, 2010), implying that there is room for improvement. Accordingly, we must learn from women who have sought abortion services about their experiences and how they would like their care to be.

A qualitative investigation of women's needs and preferences to improve care has been performed for maternity services and it offers a preliminary framework for studying abortion due to their commonalities—both birth and abortion affect pregnant women and are two among other reproductive health services that women's health clinicians provide. Bioethicist and obstetrician Anne Lyerly examined what constitutes a good birth experience by learning from childbearing women about what they valued, amounting to one of the most comprehensive efforts to date on this subject (Lyerly, 2013). She found that the five core domains for a

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good birth entail being the principal decider and actively witnessing the birth process (agency); trusting the health provider and feeling safe from physical harm in the face of risk, being free from unwanted intrusions and feeling at ease (personal security); having the birth experience respected as a significant event, being treated with dignity and possessing self-respect (respect); maintaining clear communication and access to information throughout the birthing process (knowledge); and feeling emotionally connected to the baby, loved ones, health professionals and other women (connectedness) (Lyerly, 2013).

Lyerly found that these domains for a good birth generally correspond to dimensions needed for individual wellbeing theorized by Powers et al. in their framework for social justice in health policy (Powers and Faden, 2006), implying that they are potentially broad enough to apply to other areas of healthcare. Moreover, previous studies on abortion suggest that there are parallels between women's needs in maternity and abortion care. With respect to Lyerly's domain "agency," researchers have found that women value being able to decide to have an abortion to plan their lives (Andrews and Boyle, 2003; Fielding et al., 2002) and to determine how the abortion happens (Elul et al., 2000; Fielding et al., 2002; Kerns et al., 2012; Simonds et al., 1998). Elements of "personal security" emerged in women's narratives in Kimport et al., in which women described a need to feel physically safe while obtaining care in abortion clinics that operated in hostile anti-abortion environments (Kimport et al., 2012). Findings from Castle et al. underscored the importance that women ascribe to having information to prepare for an abortion (Castle et al., 1995), consistent with the domain "knowledge." "Connectedness" and "respect" were also important to women, demonstrated as an appreciation for compassionate behavior from providers (Kimport et al., 2012; McLemore et al., 2014; Taylor et al., 2013) and having a sense of dignity upheld during abortion care (McLemore et al., 2014; Weitz and Cockrill, 2010).

Despite these commonalities in childbirth and abortion, there are also notable differences, such as women's circumstances at the time of pregnancy and the sociopolitical context within which these reproductive experiences occur. Birth tends to be viewed as joyous and physiological (Gaskin, 2011; Lyerly, 2013) and intrapartum services are well-integrated into healthcare: they are linked to antepartum and postpartum services, have private and public insurance coverage, and are accessible to most women (Kaiser Family Foundation, 2013; Rayburn et al., 2012). By contrast, abortion is politicized and stigmatized (Joffe, 2013; Norris et al., 2011). Services tend to be provided separately from other medical care in limited supply at specialized abortion facilities, requiring a majority of women to travel far and to pay out of pocket for care (Jerman et al., 2016; Jones and Jerman, 2014). Given these different contexts for birth and abortion, we sought to examine ways in which women's needs and preferences in abortion care differ from intrapartum care.

2. Methods

The study was conducted in Northern California through semi-structured intensive interviews from April to December 2014 with women who had individually experienced both birth and abortion. Participants were recruited through advertisements on Craigslist, at community colleges and at public libraries that targeted women residing in a geographical area with multiple birth and abortion facilities to choose from. We recruited women from the community rather than specific medical facilities to solicit variation in women's clinical experiences and to identify underlying patterns that were not influenced by a particular medical setting. We predicted this recruitment strategy would underrepresent women who had abortions for fetal or maternal indications given they account for less than 5% of all abortions (Jatlaoui et al., 2016). We did not view it as a limitation as those experiences have been studied (Lafarge et al., 2014). Inclusion criteria were age 18–49 years, had an abortion in the last 5 years and a prior birth at any time point in the United States, and not pregnant at the time of interview. These timeframes were selected because it has been demonstrated that women remember their births accurately and vividly as many as 10–20 years later (Simkin, 1992) but this information is unknown for abortion. All women gave informed consent prior to participating and received a $40 gift card as compensation for their time.

An obstetrician/gynecologist-researcher (AA) who had prior interview experience and did not know the participants personally or professionally conducted interviews in English over the phone and in-person in a nonmedical setting. Phone interviews allowed us to expand recruitment and to accommodate women who had childcare or transportation difficulties. AA did not identify herself as a physician unless asked as she noticed that participants shared less comfortably when they viewed her as more authoritative on the topic (Weiss, 1994). Participants were invited to describe their pregnancies by answering open-ended questions regarding the highs and lows of all their intrapartum and abortion experiences; decision to parent or not; selection of the provider and facility; interactions with the healthcare staff, support people and other patients; pain management, spiritual or religious support; and postabortion/postpartum care. Women who also wanted to discuss their miscarriages did so. We anticipated that many women would have had more than one abortion as per national statistics (Jones et al., 2017) and sought to contextualize their most recent abortion by inquiring about all of their past experiences. After sharing their stories, participants were asked to compare their preferences in birth and abortion and how they preferred care to have been. Following the interview, participants completed demographic questions and a validated Individual Level Abortion Stigma scale (ILAS) assessment (Cockrill et al., 2013) (Supplementary material). ILAS evaluates the degree of personal stigma from the most recent abortion through a series of statements about one's worries about judgment, feeling of isolation, self-judgment and sense of community condemnation. These four areas (sub-scales) are scored according to the degree of stigma. As the study took place in an area with relatively unhindered abortion access and more liberal abortion views, this scale permitted us to determine whether this context equated with less individual abortion stigma. To this end, we compared our participants' scores to the scores of a U.S.-based, regionally diverse abortion clinic population of women surveyed for the development of ILAS.

The content and style of the interview instrument were informed by consultations with experts in the field, Lyerly's work, aforementioned abortion-related studies, a narrative review of qualitative studies on abortion care (Lie et al., 2008) and a guide to abortion counseling (Perrucci, 2012). A full-spectrum doula from a different state who is not a medical professional (AOG) provided a client-advocate standpoint in the development of the instrument to complement AA's medical perspective. Full-spectrum doulas are individuals trained in providing emotional, physical and informational support during birth, miscarriage and abortion.

We used an iterative and flexible process for data collection to build a grounded theory (Charmaz, 2006). In parallel to conducting interviews, AA performed field observations of abortion and birth facilities unfamiliar to her to achieve a better understanding of care models and processes the participants described. She also spoke with doulas who provide abortion support in the geographical area studied and who have had an abortion themselves to explore potentially more sensitive questions and concepts in preparation

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