ELSEVIER

Contraception xx (2017) xxx–xxx

Contraception

Original research article

"She's on her own": a thematic analysis of clinicians' comments on abortion referral☆

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Received 20 September 2016; revised 17 January 2017; accepted 18 January 2017

Abstract

Objective: The objective was to understand the motivations around and practices of abortion referral among women's health providers.
Methods: We analyzed the written comments from a survey of Nebraska physicians and advanced-practice clinicians in family medicine and obstetrics-gynecology about their referral practices and opinions for a woman seeking an abortion. We analyzed clinician's responses to open-ended questions on abortion referral thematically.
Results: Of the 496 completed surveys, 431 had comments available for analysis. We found four approaches to abortion referral: (a) facilitating a transfer of care, (b) providing the abortion clinic name or phone number, (c) no referral and (4) misleading referrals to clinicians or facilities that do not provide abortion care. Clinicians described many motivations for their manner of referral, including a fiduciary obligation to refer, empathy for the patient, respect for patient autonomy and the lack of need for referral. We found that abortion stigma impacts referral as clinicians explained that patients often desire additional privacy and clinicians themselves seek to avoid tension among their staff. Other clinicians would not provide an abortion referral, citing moral or religious objections or stating they did not know where to refer women seeking abortion. Some respondents would refer women to other providers for additional evaluation or counseling before an abortion, while others sought to dissuade the woman from obtaining an abortion.
Conclusions: While practices and motivations varied, few clinicians facilitated referral for abortion beyond verbally naming a clinic if an abortion referral was made at all.
Implications: Interprofessional leadership, enhanced clinician training and public policy that addresses conscientious refusal of abortion referral are needed to reduce abortion stigma and ensure that women can access safe care.

Keywords: Abortion referral; Abortion; Referral; Professionalism; Crisis pregnancy center

1. Introduction

As state legislatures pass additional restrictions limiting access to abortion, women face increasing obstacles in obtaining abortion care. For many women, their primary care provider may be the first point of contact for abortion inquiry. These providers may not always offer referral, as one survey of US physicians found that only 71% of physicians who morally objected to a procedure felt professionally obligated to refer the patient [1]. Obstetrician-gynecologists' willingness to help a woman obtain an abortion varies by her medical circumstances, but family medicine and advanced-practice clinicians' opinions on abortion referral have not been well studied [2]. The combination of abortion restrictions and clinician unwillingness to refer may hinder a woman's ability to discuss and access abortion, particularly in rural areas where fewer abortion providers practice.

Our study adds to the scant literature on abortion referral by examining the motivations behind referral practices, emphasizing rural vs. urban clinicians as 89% of counties in the US have no abortion provider [3]. While many women self-refer for abortion, one study shows that almost half of

☆ Financial disclosure: The authors did not report any potential conflicts of interest.

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http://dx.doi.org/10.1016/j.contraception.2017.01.007
0010-7824/

women at a Nebraska abortion clinic discuss their pregnancy with a clinician before obtaining an abortion [4]. We analyzed the written comments from a survey of Nebraska clinicians to better understand attitudes and practices of women's health care providers in a rural state when a patient requests an abortion.

2. Materials and methods

From October 2014 until January 2015, we mailed a confidential, self-administered survey to eligible clinicians in Nebraska about their referral opinions and practices for four reproductive health scenarios, including abortion. We identified clinicians via the Health Professions Tracking Service — a database of Nebraska clinicians with an active state license — maintained by the University of Nebraska Medical Center's College of Public Health. The database contains practice location, age and specialty for physicians, nurse practitioners and physician assistants with active Nebraska licenses. We included all physicians, advanced-practice nurses (henceforth referred to as APNs including nurse practitioners, certified nurse midwives and clinical nurse specialists) and physician assistants (PAs) who self-identified their primary specialty as obstetrics/gynecology (ob-gyn), family medicine, women's health and/or nurse midwifery. We excluded clinicians in training (i.e., resident physicians). A more detailed description of our survey instrument and protocol has previously been described [5]. The institutional review boards at the University of Nebraska Medical Center and the University of California, San Francisco, approved the study.

The survey queried referral practices for a hypothetical woman with an undesired pregnancy at 7 weeks seeking an abortion, including how clinicians would refer the patient. Respondents could select all applicable options from a list of referral methods which included (a) providing clinic name(s) and/or phone number(s), (b) sending patient's records to the clinic, (c) contacting the clinic and/or clinician, (d) placing an electronic referral to a provider, (e) allowing the patient to find a provider on her own and (f) an option to write in a referral method not included listed as "other." We then asked respondents to explain their reasons for referring in that manner. At the end of the vignette, we asked participants to "Please write in any other comments you have about referring a patient for abortion."

We analyzed the survey responses thematically to depict patterns from the respondents' comments. All authors independently reviewed and familiarized themselves with the data and determined it sufficiently rich for more in-depth analysis. Two authors (V.F. and L.F.) developed one set of codes to describe the referral behavior and a separate set of codes to describe the reasons motivating the referral behavior (Table 1). Respondent's written comments to the open-ended questions primarily guided the assigned codes, while answers to the multiple-choice question on manner of referral were incorporated to get a broader sense of the respondent's practices. For respondents who selected more than one referral method, the prevailing behavior was determined from the written comments. One author (V.F.) reviewed and coded all responses, and another author (N.H.) reviewed these preliminary codes, flagging those with which she disagreed. All three authors discussed discordant responses until we reached consensus for coding categorization. We determined that the codes for the referral behavior were mutually exclusive and therefore assigned each response only one code. Many responses had more than one code apply to the reasons motivating referral behavior, and so multiple codes were assigned to those responses as needed. We tracked coding in Excel and calculated frequencies in Excel and STATA 13.1.

3. Results

Of the 496 completed surveys from the original study, 431 had comments available for analysis (Fig. 1). Participant characteristics are presented in Table 2. We found a spectrum of referral behavior for abortion services, ranging from active engagement in facilitating the referral process (18%) to providing misleading referrals (15%, Table 1). The reasons motivating the referral behavior also varied, with some clinicians reporting empathy and support for patients seeking abortion, some approaching abortion referral with the same routine as any other health care referral and others voicing objection to abortion referral for moral reasons. One urban ob-gyn reported that she would provide some patients with an abortion herself, explaining, "If the patient is known by me, [I] may take care of her myself. [...] I don't like to perform abortions, but in certain circumstances will do."

3.1. Facilitating referrals

Seventy-eight providers (18%) would facilitate the abortion referral with active assistance, such as calling the clinic/clinician directly, sending medical records or otherwise facilitating a transfer of care (Table 1). Clinicians described a fiduciary obligation to refer, often citing safety: "It is the patient's right to pursue an abortion and I would want to give her information as to the safest place to have this done." (urban family medicine PA). Clinicians recognized that referral enables patients to access services promptly: "Not a procedure I perform. Providing her with the name of a provider who will appropriately care for her is safer and faster than her getting the information out for herself." (urban ob-gyn APN). Some clinicians described being motivated by empathy for the patient (more than professional duty) and wanted to help her in the process of obtaining an abortion: "I would do everything I could to facilitate the abortion since she has a limited time window for medical abortion to be an option. I would want the patient to feel supported and respected in her decision." (urban nurse midwife).