

# The Delivery of Medical Abortion Services: The Views of Experienced Providers

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**Abstract** This study examined beliefs about the delivery of medical abortion services and current roles of 76 providers of methotrexate-induced abortion. The sample included physicians, midlevel professionals, administrators, and counselors/other medical staff. Over 75% of participants believed that, given proper training and emergency backup, physicians and midlevel clinicians alike could provide medical abortions. Over 85% agreed that methotrexate-induced abortions could be provided in any physician's office or medical facility. There were no differences in perceptions by participant group. Involvement of midlevel providers in provision of medical abortion could potentially increase access and options for women seeking to terminate an early pregnancy.

## INTRODUCTION

Since the legalization of abortion in the United States in 1973, the only type of abortion available to most American women has been surgical (suction curettage) abortion. Women's health advocates have long recognized the need for more than one abortion method. The importance that women place on individual attributes of abortion as well as the sociocultural contexts of their lives influence their comfort and satisfaction with surgical abortion. Some women may greatly prefer an alternative method that is nonsurgical and less medicalized. Medical abortion provides such an alternative.

Medical abortion, induced by drugs administered orally, vaginally, or by injection usually within 49 to 56 days of gestation has been available in some countries for over a decade. The two major drugs used to induce abortions are mifepristone, an antiprogesterin, and methotrexate, an antimetabolite. Both usually are followed by one or more dosages of the prostaglandin, misoprostol,

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administered vaginally or orally. Although many clinicians consider mifepristone the more promising of these drugs because it is more predictable and more quickly allows completion of the abortion,<sup>1,2</sup> the unavailability of mifepristone for distribution in the United States led medical researchers in the early 1990s to examine the use of methotrexate to induce abortion.<sup>3-5</sup> Methotrexate has had U.S. Food and Drug Administration (FDA) approval since 1953 for the treatment of cancer. Therefore, its off label use allows clinicians to legally prescribe this drug for medical abortion. Recently, mifepristone also became available for women in the United States. On September 28, 2000, after 12 years of political struggle, the FDA gave final approval for physicians to provide the drug for use as an abortifacient.

Both mifepristone and methotrexate have been shown to be safe and relatively effective, with completed abortion rates exceeding 90% for women with pregnancies of less than 49 to 56 days' duration.<sup>4,6,7</sup> Thus, when considering its effectiveness, in conjunction with few side effects and the early gestational age at which the abortion can take place, drug-induced abortion provides a feasible option for women who are seeking an early abortion. In particular, this method is a valuable alternative to the standard therapy of suction curettage for women who desire a nonsurgical method, prefer a method that they perceive as more natural and more private, or have life circumstances that make a drug-induced abortion a preferable option.<sup>8,9</sup> Moreover, women who have used mifepristone or methotrexate both in the United States and abroad generally have been satisfied and would choose the method again to terminate an unwanted pregnancy.<sup>8,9</sup>

The availability of medical abortion in the United States is closely tied to the issue of expanding abortion services for women. In recent years, the number and geographic dispersion of surgical abortion providers has decreased,<sup>10</sup> raising concerns about women's continued access to safe legal abortion in the United States. Moreover, a trend toward concentration of abortions in specialized freestanding clinics in largely urban settings has intensified, with almost 70% of all abortions performed in such settings.<sup>10</sup> This concentration of abortion services heightens the ability of antiabortion demonstrators and provocateurs to identify and target abortion providers and their patients. The harassment and violence directed toward abortion providers may have led many physicians to choose not to offer surgical abortions because of legitimate concerns about harassment, threats, and danger to self and family.

Although medical abortion shares certain service delivery characteristics with its surgical cousin (e.g., preabortion counseling, need for emergency backup, aftercare), it holds promise for expanding options, increasing access to services, and improving continuity of care for women in the United States who seek to terminate an early pregnancy. Medical abortion could be administered outside of an identified abortion clinic, under confidential circumstances and by a variety of health care providers. Thus, it potentially could decentralize the provision of abortion, increase the numbers, types, and geographic distribution of abortion providers and thereby reduce other barriers such as antiabortion picketing and clinic violence.<sup>10,11</sup>

To maximally increase access and options for abortion services, practitioners other than physicians will need to be allowed to provide medical abortion. In particular, midlevel clinicians such as nurse practitioners (NPs), certified nurse midwives (CNMs), and physician assistants (PAs) could be trained to routinely provide these methods. Professional groups such as the National Abortion Federation (NAF) and Clinicians for Choice have strongly advocated that qualified providers other than physicians be fully empowered to deliver all types of abortion services. Yet, all but six states have enacted laws that restrict the practice of abortion to physicians only.<sup>12</sup> Few studies have examined the beliefs of experienced abortion providers regarding appropriate

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*Practitioners other than physicians need to be allowed to provide medical abortion*

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health professionals and health care settings for the provision of medical abortion. A recent national study of health care providers found that only about one-third of obstetricians/gynecologists and family practice physicians believed midlevel providers should be allowed to offer medical abortion.<sup>2</sup> On the other hand, in Joffe's study<sup>1</sup> of a small sample of 25 providers of surgical abortion, many of whom also had some experience with medical abortion, respondents saw medical abortion as a vehicle to draw midlevel practitioners into the provision of direct abortion services.

This study examined the perceptions of experienced methotrexate abortion providers about who could provide methotrexate abortions and in what settings it could be provided. Our objectives were to: a) compare the specific roles of different health care personnel in provision of methotrexate-induced abortion; b) determine whether current providers of methotrexate-induced abortions believe that midlevel clinicians could provide this type of abortion; c) examine current providers' views about the health care settings in which methotrexate abortion could be safely provided; and d) explore the concerns of current providers related to provision of methotrexate-induced abortion by new providers and new health care settings. Health care practitioners who have recent experiences with both medical and surgical abortion regimes are most familiar with required protocols and procedures, and are, therefore, in the best position to evaluate which professional groups possess the skills and experience to adequately provide medical abortion. Because many types of professionals participate in the provision of medical abortion, including physicians, midlevel clinicians, counselors, and administrators, all of these groups were included in this study.

## STUDY METHODS

Seventy-six telephone interviews were conducted with providers of methotrexate-induced abortion during May and June of 1997. Drawing from a NAF list of facilities that offered medical abortion, snowballing sampling techniques were used to identify potential participants. With snowball sampling, it is possible that providers identified colleagues whose views were similar to their own. The fact that many different respondents often referred the same individuals suggests that we obtained good coverage of those providing methotrexate abortions in the United States.

The sample included individuals who had provided methotrexate abortions in the United States before 1997. As previously mentioned, because of the key role played by nonphysicians, "providers" included all staff who had close contact with methotrexate patients or were significantly involved in the provision of these abortions. The sample included providers from five private practices; all others worked in clinic settings. Facilities were located in 18 states. Seventy-six of the 107 providers contacted (70%) agreed to participate. The response rate among physicians was lower (53%) than among nonphysicians (82%).

The sample was composed of physicians (28%); NPs, CNMs, and PAs (13%); administrators (29%); and counselors/other medical staff (30%). The respondents were largely non-Hispanic white (89%) and were between 35 and 50 years of age (Table 1). Fifteen (20%) were men and 61 (80%) were women. The median number of methotrexate patients seen was 30, but almost 30% of the sample had provided 60 or more methotrexate-induced abortions.

Using structured interview guides, trained staff conducted 30-min telephone interviews with respondents. Responses to closed-ended questions were coded and detailed notes of participants' open-ended responses were recorded. Pretested coding schemes were developed to capture the content, themes, or sentiments of open-ended responses and comments made during the interview. The content of

**Table 1. DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE**

	N	%
Age		
Under 30	11	14.4
30 to 39	24	31.6
40–49	21	27.6
50 or older	20	26.3
Ethnicity		
Non-Hispanic white	67	89.3
Other racial/ethnic/group	8	10.7
Gender		
Male	15	19.7
Female	61	80.3
Participant group		
Physician	21	27.2
Midlevel provider	10	13.2
Administrator	22	28.9
Counselor/Other medical	23	30.3
Number of methotrexate patients		
Under 20	20	26.3
20–39	24	31.6
40–49	10	13.2
60 or more	22	28.9

these data was then summarized by a member of the team and verified by another. Descriptive and quantitative analysis of responses to the close-ended questions and the sociodemographic characteristics of the sample were conducted using SPSS (Statistical Package for the Social Sciences) software.

## RESULTS

### Current Roles

We asked participants to describe their specific roles in the provision of methotrexate-induced abortion in their facilities. Seven types of roles emerged: administrative tasks, screening, counseling, medical evaluation, preabortion ultrasound, injection, and follow-up care (Table 2). With the exception of the methotrexate injection, providers were not given a list of tasks and asked which tasks they performed. Rather they were asked an open-ended question about their roles. Therefore, the data most likely reflect what participants see as their main roles in the provision of methotrexate-induced abortions; other tasks may be underreported.

Physicians, more than any other participant group, described administrative tasks when asked to describe what roles they play in provision of methotrexate-induced abortions. Nearly two-thirds of physicians (62%) reported performing these duties—most often writing and teaching protocols, supervising staff, and having ultimate responsibility for patient care. Physician involvement with patients varied widely among facilities. Some physicians had no contact with patients except to intervene when complications arose whereas others handled all phases of the abortion. Typically physicians chose to participate in the process to some extent. For instance, 43% mentioned handling patients' initial medical evaluations, and 38% said they took part in women's follow-up care. Interestingly, just over half (57%) of the physicians

**Table 2. PERCENT REPORTING SPECIFIC ROLES IN THE PROVISION OF METHOTREXATE-INDUCED ABORTIONS BY PARTICIPANT GROUP**

	<i>Physicians</i> (n = 21)	<i>Midlevel</i> (n = 10)	<i>Administrators</i> (n = 22)	<i>Counselors and Other Medical</i> (n = 23)
Administrative tasks*	62	10	41	17
Screening†	24	30	19	26
Counseling‡	25	40	73	74
Medical evaluation§	43	80	14	48
Preabortion ultrasound	24	100	5	30
Injection of methotrexate	57	80	5	18
Follow-up care	38	60	50	30

\*Scheduling patients; handling billing, insurance, or collections; initiating, researching, writing, or teaching the protocol for methotrexate-induced abortions; supervising or having ultimate responsibility for patient care; and public relations and community education.

†Initial or final screening of patients to assess their eligibility or appropriateness for methotrexate; candidate selection.

‡Providing substantive information to patients about the abortion methods available; helping patients choose the method appropriate for them; providing emotional support; obtaining informed consent; filling out paperwork; instructing patient on how to care for herself during the abortion (when to insert the tablets, how to identify problem bleeding, using pain medication); and how to complete diaries.

§Taking vital signs, performing physical exams, drawing blood, taking medical histories; calculating the dosage of methotrexate; and lab work.

||Answering patients' questions once they have gone home after the injection; performing the postabortion ultrasound; handling follow-up visits.

surveyed gave the methotrexate injections themselves. Among them, some reported that state regulations or insurance companies require that they do so.

Data indicate that midlevel providers play a prominent role in the provision of methotrexate-induced abortions. All ten midlevel professionals surveyed reported doing preabortion ultrasounds, eight handled medical evaluations, eight gave methotrexate injections, six handled follow up care, and four performed counseling duties. Not surprisingly, midlevel personnel often serve as the principal provider for the methotrexate patients in their facilities.

One of the principal duties of administrators, counselors, and other medical staff was to ensure that women had appropriate knowledge and information about both methotrexate and surgical abortions. Almost three-quarters of administrators, counselors, and other medical staff indicated that they were responsible for some level of counseling in their facilities. Forty-one percent of staff classified as administrators reported being responsible for administrative duties and half also participated in follow-up care, often handling off hours calls. Few were involved, however, in the more medical aspects of methotrexate abortions. Nearly half (48%) in the counselor and other medical group reported taking part in medical evaluations and almost one-third (30%) performed preabortion ultrasounds and/or provided follow-up care for patients. Eighteen percent reported giving the injections.

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*Midlevel personnel often serve as the principal provider*

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## Appropriate Providers and Settings

### *Appropriate Providers*

All participants were asked if they agreed or disagreed with the statement: "Given that they are properly trained and have access to appropriate emergency backup, any physician could provide methotrexate-induced abortions." They were also asked if they agreed or disagreed with the same statement for the following three health professionals: PA, NP, and CNM. The majority of participants felt that physicians

and midlevel providers alike could appropriately provide methotrexate abortions (Table 3). Given that the health professional is properly trained and has access to emergency backup, 73% reported physicians were qualified providers of methotrexate abortions. The percentages who agreed that other health professionals were qualified were even higher: 85% for NPs, 88% for CNMs, and 80% for PAs. Chi-square tests showed no significant differences among the four respondent groups. The responses of physicians mirrored closely those of participants as a whole. In fact, physicians were somewhat more likely to report that any NP or CNM could provide a methotrexate abortion (95%) than they were to report that any physician could (76%)

An opinion voiced by many participants, regardless of whether or not they believed nonphysicians should provide medical abortion, was that providers of methotrexate abortions should have specific medical training and skills. Sixteen percent commented that methotrexate providers should be trained in obstetrics/gynecology, or have specialized training in women's health. Twenty-one percent believed these providers, as a condition of qualification, must have the experience of performing surgical abortions; 12% stated that providers needed to have some training in surgical abortion even if they did not actually perform them. Finally 9% said the methotrexate providers must have access to and/or be able to perform an ultrasound. Many believed that these competencies were a prerequisite to offering medical abortion. The following quotes illustrate these points of view:

I agree [that any physician can provide methotrexate-induced abortions], I suppose, but I have concerns. The risk is that the general practitioners will think that they can just give it. I can see them getting into horrendous problems, such as methotrexate-exposed fetuses. They also have to be adept at ultrasound, and have it available. They have to have the ability to take care of patients facing emergency situations—be able to do a D&C and to have backup. (physician)

I think the provider should be a gynecologist who can do a D&C. Someone who can provide surgical care if the patient needs it. With medical abortion there is a certain percentage where they need a D&C. I don't think it's fair to dump them in an emergency room. (administrator)

Respondents also emphasized the importance of meeting the emotional and informational needs of patients. Twelve percent commented that a qualified provider must be able to meet the psychosocial needs of women facing an abortion, or they must have staff members who can do so. These concerns, expressed most frequently by participants who provided abortion counseling, were usually directed at physicians. Indeed, only 61% of participants categorized as "counselors and other medical staff" agreed that any physician could provide methotrexate-induced abortion. The majority of their concerns centered on issues of appropriate counseling, taking time with patients, and physician' recognition of the need to hire the appropriately trained staff if they cannot take the time themselves. For instance, one participant stated:

Physically, yes [any doctor could give a methotrexate-induced abortion], but emotionally I disagree . . . the counseling involved is important. Lots of doctors' offices don't have people to provide the emotional counseling, and doctors often don't have the empathy skills either. So they need to have the counseling staff to meet the emotional needs of women. (counselor/other medical)

Ten percent also voiced concerns about continuity of care, often relating their concerns to medical training of abortion providers and/or their ability to perform surgical abortions. The ability to follow through with all levels of care

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*A qualified provider must be able to meet the psychosocial needs of women*

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**Table 3. PERCENT WHO AGREE THAT PROVIDERS AND SETTINGS ARE APPROPRIATE FOR METHOTREXATE ABORTION BY PARTICIPANT GROUP**

Group	Any Physician	Any NP	Any CNM	Any PA	Any Medical Facility	Any Doctor's Office
Physicians	76	95	95	76	81	86
Midlevel providers	80	90	100	90	100	90
Administrators	81	81	81	76	82	82
Counselors and other medical	61	77	82	82	87	87
Total	73	85	88	80	86	86

was particularly important to those who felt that women should stay with one provider throughout the procedure.

My concern is really the continuity. I feel strongly that the same person who handles the medical abortion should be able to perform a surgical abortion if it fails. A woman already has rapport with the doctor. To juggle them around would be difficult emotionally, I would think. I think it is important for the same person to do the pelvic, the ultrasound, and the D&C. (counselor/other medical)

Despite the concerns expressed, most participants seemed confident in the abilities of midlevel clinicians, especially CNMs, to successfully and safely administer methotrexate. As one person summed up the prevailing sentiment, "A midwife can deliver a baby. She can handle an abortion." This high level of approval is undoubtedly due to nurse-midwives' focus and training on women's reproductive health.

Finally, 10 respondents (13%) spontaneously mentioned that being prochoice was essential for those involved in women's health care.

I don't think physicians should [offer methotrexate] if it's just one of the office procedures they offer. They need to look at it as an important service. To have a political conscience. To believe in abortion and a woman's right to choose. (midlevel provider)

### *Appropriate Settings*

All participants were asked if they agreed or disagreed with the statement: "Methotrexate-induced abortions could be safely provided in a medical facility that does not perform surgical abortions as long as they had access to appropriate emergency backup." They were also asked if they agreed or disagreed with the same statement for provision of abortion in any physician's office. Eighty-six percent agreed that methotrexate-induced abortions could safely be provided in a medical facility that does not offer surgical abortions as long as access to appropriate emergency backup was available. Similarly, 85% agreed that methotrexate could safely be provided in any physician's office. No significant differences were found in levels of agreement among the four participant groups. Nearly all who disagreed or had concerns with these questions cited reasons surrounding continuity of care.

For example, several respondents were concerned about emergency backup plans if the clinic itself did not offer surgical abortions. They felt that relying on an emergency room to handle problems was not only risky, but might augment an already traumatic experience.

I disagree [that methotrexate could be provided in a facility that does not do surgical abortions]. A general physician could do this procedure, but we're

ultrasounding again to make sure the tissue has passed. If it's offered by a nonabortion provider, there will be more people in the ERs, more complications related to tissue not passing. In most ERs, there isn't even a GYN resident available. (administrator)

Methotrexate should only be provided in a center that is known to provide that type of [abortion] care all the time. Otherwise it may be a careless arrangement. I suppose you *could* do it if a hospital emergency room is available and willing to take them, but you know a lot of ERs won't. (physician)

Others were concerned about a woman's emotional health and the negative outcomes she might face if surgical abortion were not readily available. This group felt that by offering both surgical and medical abortion, a clinic would provide not only a healthier, more stable environment, but also more choices for women. As one respondent commented:

Well, that's the goal—to make it more accessible. But the problem is that surgical abortion is not necessarily seen as an emergency. I wouldn't want to see her have to explain everything to another provider; sit and wait in another place with people she hasn't met before. Ideally, a woman should have more continuity. (midlevel provider)

## DISCUSSION

The current findings suggest that midlevel providers can and do play a critical role in the provision of abortion options for women. Despite state legislation that greatly limits the role of midlevel providers, in our study these clinicians appear to be actively participating in all aspects of the provision of methotrexate abortion, particularly the medical aspects. Moreover, the vast majority of current providers of medical abortion, the group presumed most knowledgeable about the skills and training needed to provide this service, agree that any midlevel provider, given proper training and access to appropriate emergency backup, could safely administer methotrexate. This finding concurs with Joffe's<sup>1</sup> conclusions based on a small sample of providers of surgical abortion, most of whom had some experience with medical abortion. It does, however, partially conflict with results of the 1998 Kaiser Family Foundation national survey.<sup>2</sup> The survey found that 82% of NPs and PAs believed that midlevel providers like themselves should be allowed to offer medical abortions, but only 29% of obstetricians/gynecologists and 39% of family practice physicians agreed. The reasons for differences in physician attitudes between studies may in part be attributed to whether or not the providers surveyed have been involved in the provision of abortions, either medical or surgical.

Midlevel professionals have the opportunity to be pioneers in the provision of new abortion services. Moreover, the greatest potential for increasing women's abortion options and access may rest with midlevel practitioners. In the recent Kaiser Family Foundation survey<sup>2</sup> only 2% of NPs and PAs had ever provided surgical abortion but 54% stated they would be likely to offer mifepristone if it were approved and legal for them to do so.

Although participants in the present study were not specifically questioned about mifepristone, our findings would appear to also apply to the provision of mifepristone-induced abortion. Mifepristone abortions generally require less time and effort for providers as they are completed more quickly. Indeed, when our sample was asked about satisfaction with methotrexate, 12 respondents spontaneously mentioned mifepristone, with 5 indicating that they clearly preferred mifepristone.<sup>13</sup>

While most participants believed that any properly trained physician or

midlevel provider could safely offer methotrexate-induced abortion, many voiced concerns about proper training, the availability of counseling services, and continuity of care. The attitudes and beliefs of these experienced abortion providers, particularly the belief that health professionals should not provide medical abortions unless they also provide surgical abortions, could pose a significant barrier to increased access to medical abortion. On the other hand, these beliefs reflect legitimate concerns and suggest that midlevel providers should have the opportunity to receive comprehensive training in abortion care, including the physical, emotional, and political aspects. Moreover, medical abortion techniques should be included as an option in the training curricula of all qualified provider groups.

The current political climate in the United States and state laws and statutes, however, may limit the involvement of midlevel clinicians in the provision of medical abortion. Professional organizations and women's health advocates must, therefore, continue to challenge physician-only laws that restrict qualified midlevel practitioners from providing abortion, proposed legislation to limit the prescription of medical abortion to surgical providers,<sup>12</sup> and current FDA regulations that only allow physicians to perform or supervise the provision of mifepristone-induced abortions.<sup>14</sup> The majority of participants in our study agreed that medical abortion could be safely provided in multiple types of facilities. The provision of medical abortion in more varied health care settings in combination with an influx of midlevel providers could increase access to and quality of abortion services. For example, decentralizing the provision of abortion and including the practice as a component of reproductive health care offered in a provider's private practice would increase availability. Moreover, without the visibility of specialized clinics, abortions could be provided under more confidential circumstances, thereby eliminating the threat of harassment and violence. Thus, women would not be subjected to harassment by antiabortion picketers, which may cause negative psychological consequences.<sup>15</sup>

One critical concern voiced by current providers involved continuity of care, specifically in the case of a failed drug-induced abortion and the need for a surgical procedure. These concerns fail to consider that, in fact, a woman might experience better continuity of care if her primary care provider could administer the abortion when her choice of method was medical abortion. Abortions might be less anxiety-provoking for women if the service was offered at their primary health care facility. In addition, the provision of services by midlevel clinicians in the woman's primary care setting may increase patient satisfaction, because midlevel providers may have more time than physicians to be involved in the multiple patient-related services associated with medical abortion, thus further contributing to continuity of care.

Another theme that was evident in providers' remarks involved the importance of options for women. We think it important that multiple methods of abortion, medical and surgical, be available to U.S. women. Given the current political climate in the U.S., any abortion method that can be nonobtrusively provided by midlevel clinicians can increase women's choices and perhaps their satisfaction with service delivery.

This study has several limitations that need to be considered when interpreting results. The relatively small sample was not representative. Moreover, there were differences in response rates between physicians and other groups, with fewer physicians agreeing to participate. The physicians who participated in the study could be a relatively select group, more likely to support the expansion of providers and settings for medical abortion than physicians who refused to participate or could not be contacted. Also, health care providers in general may be much less accepting of midlevel clinicians as medical abortion providers than were the experienced abortion providers in our sample.

Despite these limitations, the study strongly supports efforts to extend the provision of medical abortion to new health settings and midlevel clinicians. Such changes, if implemented, are likely to increase access and options for women seeking to terminate an early pregnancy.

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