Contraception

Contraception 95 (2017) 470–476

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).

Table 1
Referral behavior of Nebraska clinicians for a woman seeking an abortion (N=431)

Referral behavior		Definition	Primary motivation	Example of a quote	Urban	Rural	Total
Facilitating		Referrals that facilitate "transfer of care" through phone call, paperwork, record, etc.	Professional duty Empathy for patient Safety Efficiency Safety Privacy	"She is asking for help. It is my job to help her." — urban family medicine PA "I would want to make sure that patient had considered the options and had not been pressured by someone else to have an abortion. That being said, she needs support upon making the decision." — urban family medicine physician	44 (18)	34 (18)	78 (18)
Just-the-name		Referrals that give enough information to contact a clinic that provides abortions.	Patient autonomy Avoid staff conflict Safety Referral not required	"Patient has a right to terminate if she desires." — rural family medicine physician "Places that provide abortions do not need referrals from us for care." — urban ob-gyn physician	100 (41)	66 (35)	166 (39)
Nothing		Patient is on her own. No information provided by clinician.	Moral/religious objection Lack clinic knowledge Clinical scenario not encountered	"I have a moral obligation not to refer her" — rural ob-gyn physician "Do not know referrals for this. Have never been asked either." — rural family medicine APN	68 (28)	56 (30)	124 (29)
Misleading	Passive delay	Provider referring to a doctor, but not an actual abortion provider.	Moral/religious objection More evaluation needed Promote continuation of pregnancy	"Because of my religious beliefs I do not refer patients desiring abortions." — urban family medicine physician "I would refer the patient to counseling and other social service groups to help treat the emotional distress first and assist the woman in making the choice that she believes to truly be the right decision," — rural family medicine PA	10 (4)	11 (6)	21 (5)
	Active dissuasion	Provider referring to a crisis pregnancy center, adoption services, social worker or therapist.	Moral/religious objection Coerce continuation of pregnancy	"I would not refer her to get an abortion. I would encourage her to do her own investigation. I would direct her to places like Crisis Pregnancy centers that help with all options of unplanned pregnancies — not just abortions." — urban family medicine PA	22 (9)	20 (10)	42 (10)

Data are as N (%).
Responses with no comments were excluded from analysis. Percentages add to more than 100 due to rounding.

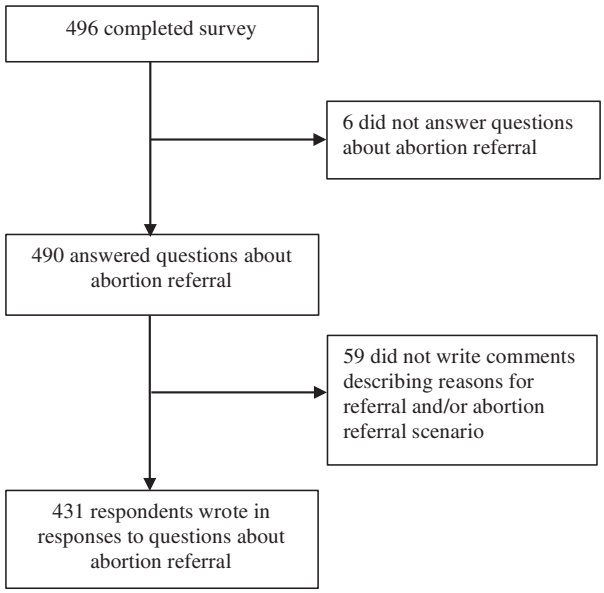

Fig. 1. Flowchart of surveys completed by Nebraska clinicians about abortion referral.

However, given existing controversy and stigma around abortion, some clinicians explained that abortion referrals merited a heightened concern for privacy. Abortion stigma is the social understanding that abortion is undesirable or immoral in a way that diminishes the value of the person having or providing it [6]. While abortion stigma was detected in all categories of referral, it explicitly shaped how five clinicians articulated their referral behavior, as a rural family medicine APN states, "Patient may not want additional information sent. Patients don't want 'connection' to the clinic providing the service. Because of the stigma, I feel these services are not openly communicated." Clinicians also feared a negative reaction from the community if abortions or abortion referrals were to become known: "We are such a conservative community that we have to be careful to not attract pro-life activity — we support women however!" (urban ob-gyn APN).

3.2. Just-the-name referrals

One hundred and sixty-six (39%) indicated that they would refer the patient by providing the clinic name and/or phone number (Table 1). Some clinicians expressed that patients should make the abortion appointment themselves for their decision to be truly autonomous (n=68, 13%), as an urban family medicine APN stated, "This is a very personal choice and I think the best way to do this is to let the patient make the call and time of appointment. I would get her the information and allow her to do the rest." Other clinicians took this idea further and described that making an appointment could be coercive, as one rural family medicine PA said, "I feel the patient needs to make her own appointment. If I make the appointment, I don't want the patient to feel she 'has to go' because she already has the appointment. It needs to be her decision without any coercion from anyone including me." Interestingly, these clinicians citing patient autonomy as a motivation for just-the-name referrals were more concerned that facilitating the appointment would push a woman toward abortion than how not facilitating a referral might pose a barrier.

Clinicians explained that abortion referral can create tension within the clinic, as an urban family medicine physician reported that the reason she only provides patients with the clinic name is "to avoid breaching confidentiality or making my nurses uncomfortable by having to make appointment." Intraclinic tension presents additional challenges for APNs and PAs when a discrepancy with their supervising physician arises, as an urban family medicine PA said, "My supervising physician/practice does not refer for elective abortion — we will direct them to counseling [about] all their options and let them make choice/appointment." Clinicians also pointed out that a formal referral is not required to access care: "Abortion clinics typically do not need a referral. I would provide any information they needed, but I would not contact them." (urban ob-gyn physician).

3.3. No referral

One hundred twenty-four (29%) clinicians reported they would do nothing in the way of referral. Moral objection represented the most common reason clinicians did not refer for abortion, as a rural family medicine physician said, "Morally, I don't [refer for abortions]. Patients wanting abortions don't have any difficulty finding a clinic in the city. I've never been asked in 25 years." Religious objections to abortion also motivated the absence of abortion referral: "I don't believe in abortion for religious reasons and feel

Table 2
Characteristics of survey respondents

Characteristic	*N*=431 (%)
Age (mean±SD), years	46.7±11.6
Gender	
Male	154 (36)
Female	277 (64)
Marital status	
Single	52 (12)
Married	371 (88)
Children	
None	44 (12)
One or more	328 (88)
Race	
White	401 (96)
Nonwhite	17 (4)
Practice characteristics	
Specialty	
Obstetrics and gynecology	87 (20)
Family medicine	344 (80)
Clinician type	
Physician	204 (47)
Advanced-practice nurse	116 (27)
Physician assistant	111 (26)
County of practice[a]	
Urban	244 (57)
Rural	187 (43)
Obstetrics services offered in practice	253 (60)
Standardized referral process	280 (67)
Years in practice (mean±SD)	15.9±11.1
Years in practice in Nebraska (mean±SD)	14.6±10.6
Religious characteristics	
Religion	
None	28 (7)
Protestant	251 (60)
Catholic	128 (31)
Other	11 (3)
Attendance at religious services	
Never	42 (10)
Once a month or less	110 (26)
Twice a month or more	265 (64)
Intrinsic religiosity	
Low	180 (44)
Moderate	98 (24)
High	130 (32)

Numbers and percentages are unweighted. Percentages may add to more than 100 due to rounding.
Some groups add to less than 431 because of missing responses.
Data presented as *N* (%) or mean±SD.
[a] Rural vs. urban county based on the Office of Rural Health Policy definition and coded by respondent zip code.

uncomfortable assisting in this process. I think these services are easily accessible for patients on the Internet and in the phonebook." (urban ob-gyn physician). Other clinicians referenced religious beliefs but supported patients seeking abortion: "I'm Catholic and pro-choice." (urban ob-gyn physician).

Clinicians cited not knowing where to refer a patient as a reason for not providing a referral: "Honestly, no idea. This would take great research on my part with input from the patient regarding distance willing to travel. I know there are very few clinics offering this service in Nebraska." (rural family medicine PA). Other clinicians reported they had not found that their patients needed or requested abortion referrals, as one urban family medicine physician stated, "Has not come up with any of my patients."

3.4. Misleading referrals: passive delay and active dissuasion

Sixty-three clinicians (15%) provided misleading referrals to clinics or centers that do not provide abortions. Instead, they referred the woman to an ob-gyn, adoption agency, crisis pregnancy center and/or a therapist. Some clinicians felt that women need additional counseling before an abortion referral, incurring a passive delay: "I would discuss with patients all the options and would encourage patient to be seen by OB for consultation." (urban family medicine physician). Some respondents would promote continuation of the pregnancy, intentionally omitting abortion clinics: "I am very pro-life. So without saying that I would ask if she would be interested in the idea of adoption. If she says no, I will honestly go no further but I will not help either." (urban ob-gyn APN).

Other clinicians described actively dissuading patients from seeking abortion: "I would encourage the mother not to end the life of her 7-week infant." (urban family medicine physician). Some clinicians referenced a crisis pregnancy center (CPC) as a resource for patients seeking abortion. CPCs are nonprofit organizations, often with conservative Christian affiliations, that offer free services to pregnant women, including pregnancy tests, counseling and ultrasounds, but do not provide abortion services. Some clinicians would specifically refer a woman to a CPC to receive counseling to dissuade her from having an abortion: "We do not provide referrals for abortions. I would explain that policy, discuss local options for crisis pregnancy (pro-life) care and let her make the decision." (urban family medicine physician). Other clinicians did not appear to be aware that CPCs do not offer abortions because five indicated that they would refer to both an abortion clinic and a CPC. One urban family medicine APN showed support for a woman accessing abortion, "I find that contacting the clinic on the patient's behalf helps the collaborative effort and continuity of care of the patient," yet wrote in the name of a CPC as a referral location.

4. Discussion

We thematically analyzed Nebraska clinicians' attitudes and opinions on abortion referral. Over half of the clinicians surveyed would provide an appropriate abortion referral either by facilitating a transfer of care to the abortion clinic or by giving a woman the abortion clinic name and/or phone number. Almost one in three clinicians would provide nothing in the way of referral, and one in seven would give a misleading referral. Respondents described a variety of motivations for their abortion referral practices, including

valuing patient autonomy, empathy and support for the patient, professional duty, religious and moral objection, and not knowing where to refer patients.

Abortion sits within a complex social and ethical framework in our society. Clinicians have been found to adjust their level of participation with an abortion depending on the circumstances around a pregnancy, as a recent study found that a doctor's willingness to support, refer for or provide abortions varied based upon the doctor's evaluation of the morality of that particular abortion [7]. Of the prominent concepts used in medical ethics, clinicians in our study cited autonomy and beneficence most commonly when deciding how to approach a woman seeking an abortion. Respecting a patient's reproductive autonomy allows women freedom to make pregnancy decisions placing her needs and values before the clinician's [8]. Those who highlighted beneficence cited concerns about safety. Clinicians may be concerned that, in the absence of referral, women may not obtain a safe abortion.

Abortion stigma affects women's well-being, increasing psychological distress and social isolation [9]. The stigma around abortion can also negatively affect the health of women who obtain abortions [10]. Clinicians who fail to routinely discuss abortion during pregnancy options counseling perpetuate this stigma at the expense of women's health. Clinicians, particularly those in rural or conservative areas, may be disinclined to address abortion out of fear that abortion opposition will threaten their practice [11]. Our results highlight that stigma can shape how clinicians who do refer approach the process, ranging from providing a "just-the-name" referral when a patient may have wanted a direct connection with a clinic to avoiding discussion of abortion referral with other staff. Furthermore, clinicians citing that their patients do not need abortion referrals may simply be unaware, as women tend to not to disclose when they fear disapproval [12].

Many professional organizations have statements about the necessity of providing a pregnant woman with comprehensive options counseling, including information about where she may obtain a safe abortion [13–18]. Standard medical care may at times conflict with a clinician's personal moral beliefs, leading the clinician to refuse care, make a referral or give information. The American College of Obstetricians and Gynecologists states that while individuals may personally oppose abortion, they must not impose their personal beliefs upon patients nor impede women from accessing abortion services [19]. Clinicians who do not refer patients requesting abortion disregard their professional obligation to ensure safe care for women.

Growing numbers of abortion restrictions have closed abortion clinics in some parts of the United States, resulting in substantial burdens for women to access care [20]. Clinicians may desire to help patients navigate the increasingly cumbersome process accessing abortion, but our study found that 1 in 10 clinicians does not know where to refer patients. Overcoming referral inexperience or knowledge deficit may be ameliorated more easily than overcoming moral objections. Adequate clinician training on abortion referral is a public health necessity so women can access safe and timely care. Scholars have called for improved provider knowledge about abortion referral, and organizations exist to help providers enhance referral practice in their area [21,22].

Our study strengths include the large number of written comments analyzed in which providers responded to open-ended queries to explain reasons for referral types. The respondents included an assortment of clinician types (PAs, APNs and physicians; family medicine and ob-gyn), all of whom encounter pregnant women. Our analysis illuminates the diverse feelings around abortion referral in a Midwestern, mostly rural state. Limitations include that responses to a hypothetical scenario may differ from real-life responses, as the social and medical circumstances around a woman's decision to have an abortion change a clinician's willingness to help her obtain one [2]. Our results provide a starting point when considering the motivations around abortion referral, but we are cautious to apply them more generally. We do feel that the large number of comments in the analysis characterizes the range of approaches to abortion referral and that further quantitative research is needed to better understand the prevalence of the views shared by our respondents among clinicians. For a broad understanding of abortion referral, we created categories for referring behavior and motivations that convey clear distinctions. In reality, groups overlapped considerably and sometimes had contradictions within the responses. We recognize that these rigid categories fail to express nuance in clinicians' responses, but we conveyed the prevailing trends.

We call on the interprofessional leadership of individual health care systems to cultivate and support local policies on patient-centered pregnancy options counseling and abortion referral. At a minimum, our findings support additional training and outreach to clinicians caring for pregnant patients about abortion referral. More broadly, a public policy approach that addresses conscientious refusal would standardize provision of referral. Improved clinician referral would reduce abortion stigma by normalizing abortion as the common medical procedure that it is and promote women's health by ensuring continuity of care. As health care professionals, we have a duty to provide comprehensive, unbiased pregnancy options counseling including abortion referral.

Funding

This work was supported by the Society of Family Planning (SFPRF14-9).

Acknowledgments

None.

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