# Telemedicine Abortion in Primary Care: An Exploration of Patient Experiences

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## ABSTRACT

**PURPOSE** The purpose of the study was to explore patients' experiences and perspectives obtaining telemedicine medication abortion (TeleMAB) through their primary care health system.

**METHODS** We conducted in-depth telephone interviews with 14 English-, Spanish-, and/or Portuguese-speaking patients who received a TeleMAB between July 2020 and December 2021, within a large primary care safety-net community health system in Massachusetts. We created and piloted a semistructured interview guide informed by patient-clinician communication frameworks and prior studies on patient experiences with TeleMAB. We analyzed data using reflexive thematic analysis and summarized main themes.

**RESULTS** Overall, participants found TeleMAB services in their primary care health system acceptable, positive, and easy. Participants discussed how TeleMAB supported their ability to exercise control, autonomy, and flexibility, and decreased barriers experienced with in-clinic care. Many participants perceived their primary care health system as the place to go for any pregnancy-related health care need, including abortion. They valued receiving abortion care from their established health care team within the context of ongoing social and medical concerns.

**CONCLUSIONS** Patients find TeleMAB from their primary care health system acceptable and beneficial. Primary care settings can integrate TeleMAB services to decrease care silos, normalize abortion as a part of comprehensive primary care, and improve access through remote care offerings. TeleMAB supports patients' access and autonomy, with the potential to benefit many people of reproductive age.

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## INTRODUCTION

Decades of abortion restrictions decrease equitable access to care, contribute to America's growing maternal mortality crisis, and exacerbate abortion stigma.[1-5] State-specific restrictions have singled out abortion providers and patients, enacting laws that are medically unnecessary and politically motivated. Laws include complete abortion bans, gestational duration limits, waiting periods, insurance coverage, unnecessary ultrasounds, need for specialized ambulatory surgical centers, and restrictions on telemedicine.[6] Restrictions further marginalize underserved communities, disproportionately affecting people who identify as Black, Indigenous, and people of color (BIPOC) who make up about 70% of those who obtain abortion services.[7,8] These inequities have worsened since June 2022 with the U S Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* (*Dobbs*) with almost one-half of all US states subsequently severely restricting or banning abortion care altogether.[9]

Primary care plays a critical role caring for the most underserved populations in the US health care system.[10-12] Yet, before the *Dobbs* ruling few primary care practices offered abortion; 95% of abortions occurred in stand-alone clinics outside of where patients get their usual medical care.[13-16] Importantly, abortion in primary care settings has been shown to be safe, feasible, and effective.[17-20] In addition, some patients prefer abortion within primary care, compared with independent abortion clinics, for reasons of trust, familiarity, privacy, and provider comfort.[21-23]

During the 2019 coronavirus pandemic (COVID-19), several primary care practices initiated direct-to-patient telemedicine medication abortion (TeleMAB)

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and mailed pills to patients.[24] Research shows that TeleMAB by primary care is feasible and efficient.[25,26] To date, however, no studies have evaluated patients' experiences regarding obtaining TeleMAB through their regular primary care health system.[27,28] Patient experience is an important aspect of patient-centered care and to thus understanding their perceptions enhances the delivery of care.[29] Therefore, we interviewed patients who completed TeleMAB through their primary care health system to understand their experiences.

## METHODS

### Study Design, Setting, and Sample

From March-May 2022, we interviewed a convenience sample of patients who received TeleMAB within a large primary care safety-net community health system in Massachusetts. This health system cares for a culturally diverse patient population of approximately 120,000 patients who mostly hold public or subsidized health insurance. Eligibility criteria included patients who received a TeleMAB between July 28, 2020 and December 31, 2021, had medications delivered, and spoke and understood English, Spanish, and/or Portuguese (n = 47). Using electronic medical records, D.N. generated a list of eligible participants. Interviewers called patients via encrypted teleconferencing software up to 5 times over 2 weeks and shared study information. Consent forms were e-mailed in the participant's language or patients provided verbal consent. D.N. did not call any patient for whom she had provided care and only identified as a researcher and not a physician. The 2 Institutional Review Boards of the involved institutions, University of Washington and Cambridge Health Alliance, approved this study. We followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) reporting guidelines.[30]

### Telemedicine Medication Abortion Workflow

Primary care clinics in this health system began providing in-clinic medication abortion (MAB) in 2003. In July 2020 the health system implemented direct-to-patient, TeleMAB services, which entailed the use of video visits or synchronous telephone calls between the clinician and patient. When patients expressed the need for a medication abortion, the health system offered them in-clinic or TeleMAB appointments. For patients who chose TeleMAB, the clinician assessed eligibility for remote care including patient location in Massachusetts at time of visit and assessment of gestational dating and ectopic pregnancy risk based on clinical history. The clinician counseled eligible patients on expected process, e-mailed consent forms for electronic signature, and placed a pharmacy order to send a package which was delivered by the health system's courier with mifepristone, misoprostol, anti-nausea medications, analgesics, a urine pregnancy test, and an instruction printout. The clinic scheduled each patient for a 1- to 2-week follow-up telemedicine appointment. Patients could choose to have any or all aspects of care via telemedicine or in-clinic.

### Data Collection

We created a semistructured interview guide (Supplemental Appendix, 1.0 - 2.0) informed by the Miller patient-provider communication framework, prior studies on patient experiences with TeleMAB, and the research team's ongoing work exploring patients' experiences with TeleMAB at a primary care–based reproductive health clinic.[31-34] We chose Miller's framework because it includes key components of patient-centered communication and the medium of communication used, ie, telemedicine. Interviewers (D.N., S.S., A.E.F.) each pre-tested the guide with people of reproductive age and refined the questions based on their feedback (Supplemental Appendix, 3.0). All interviews were audio recorded, transcribed, and quality checked.[35,36] After the interview, participants self reported sociodemographic characteristics (Supplemental Appendix, 4.0) and received a $50 gift card.

### Analysis

S.S. and A.E.F. performed the study analysis using reflexive thematic analysis.[37] They read transcripts, made conceptual notes, met to discuss potential codes, developed a codebook, and considered how the constructs related to a broader framework of patient experience. S.S. and A.E.F. used Dedoose software (SocioCultural Research Consultants) to manage, sort, and code data. They simultaneously coded 4 transcripts, discussed discrepancies in coding after each one, and refined the codebook accordingly. They coded the remaining transcripts independently (5 each) and met to refine study findings. The analytic team reached data saturation on key themes.[38]

### Research Team and Reflexivity

D.N., A.T., and H.M. are family physicians who provided primary care including abortion at the study site. H.M. spearheaded TeleMAB implementation at the study site in June 2020. H.M., A.T., and D.N. were mentored and trained in key concepts of qualitative research by A.E.F. at the beginning of this study. S.S. is an MPH graduate and is a PhD student with a focus on reproductive health research with 4 years of experience conducting qualitative research. A.E.F. is a PhD graduate in public health with experience working in abortion policy and qualitative research. E.M.G. is a complex Family Planning Fellowship–trained practicing physician with master-level training in qualitative research. In terms of reflexivity, the team used Miller's framework which is based in patient-centered communication to shape the collected data and analysis. The analysts incorporated a reflexive process that deepened interpretations of the data and helped build cohesive and structured findings while reflecting on their own biases. A.E.F. is pro-telehealth and medication abortion, and A.F., D.N., H.M., and E.M.G. are pro-primary care, which may have influenced our interpretation of the data and the summary of findings.

## RESULTS

Of 47 eligible patients, 14 (30%) agreed to an interview, 9 declined, 9 hung up after our introduction, 1 did not remember their appointment and was not interviewed, and 14 did not respond. One participant did not provide demographic information due to limited time. The other 13 participants identified as female, aged 26 to 42 years, and 10 (71.4%) were parents to children aged 8 months to 15 years. Six (42.8%) identified as African American/Black, 3 (21.4%) as Asian/Pacific Islander/Native Hawaiian, 2 (14.3%) as White and Black, 1 (7%) as White, and 1 as Hispanic/Latino. Eleven were interviewed in English, 2 in Portuguese, and 1 in Spanish.

### Ease of Process of Obtaining TeleMAB in Primary Care

Overall, participants found TeleMAB in primary care acceptable, beneficial, and straightforward (Table 1). Participants felt provider counseling prepared them well and expressed confidence in having necessary information to successfully complete their abortion. One noted, "I was very confident and relaxed that everything was going to go right. They made me feel good about it. I wasn't scared" (ID 10, age unknown). They received clear instructions regarding medication use, expected side effects, and contact information for questions. Additionally, participants highlighted how caring interactions with staff amplified the ease of the process. For example, one participant, who initially felt overwhelmed by their pregnancy-related decisions, ultimately felt the experience was easy because of the support they received from their clinician and support staff.

Participants felt comfortable calling the health system or using their online patient portal to contact their providers to schedule appointments or ask questions. They shared having positive experiences with the medication delivery system, noting the simplicity and reliability of the service: " [The

**Table 1. Excerpts Illustrating Patient Experience With TeleMAB Within Primary Care**

| Theme | Description | Illustrative Quotes |
|---|---|---|
| **Ease of process of obtaining telemedicine medication abortion in primary care** | | |
| Patient-centered counseling and preparation | Participants reflected on having effective, patient-centered counseling throughout their TeleMAB experience and having clearly communicated instructions on how to use the medications and what to expect. Clinicians were also perceived as kind and non-judgmental. This enhanced participants' comfort and confidence with their TeleMAB. | #1 "Everything went well, the support they gave me, the information they gave me was complete and the process was exactly like the doctor told me it was going to be and everything turned out fine." (ID 3, age 28)<br>#2 "She called again, [after the initial consultation], offered me support and she guided me through the steps on how to take medicine, what I'd feel, any side effects, if there were any issues - that they're just a phone call away… Very friendly. And again, they were great as far as support and everything." (ID 10, unknown age)<br>#3 "Just dealing with people, making medication easy and making it simple to understand how to take it, the whole experience for me, someone who didn't plan to be pregnant, it was the most easy experience I've ever been through. And I would never have ever expected to go through an abortion experience like that, to be so simple." (ID 33, age 26) |
| Simplicity of the service | Participants found the process of scheduling appointments, contacting providers, and using the medication delivery system familiar, simple, easy, and reliable. | #4 "So, every time I needed to speak to her or set up an appointment, I was able to get a hold of either her or the other doctor that was in my case. They were there when I needed help." (ID 48, age 31)<br>#5 "They set up a date to send the medication to my home, and a person delivered it to my hand. I had to sign the form, and I did the procedure at night." (ID 15, age 31)<br>#6 "I trusted [the primary care system] and I knew how the process went, and I knew some of the people, and how things would go… I know how to message them and how to call them. Things like that made it feel familiar and easy to engage in. … Versus, I've never actually talked to anyone at [an abortion clinic] ever. So I'd have to figure out how to even set it up. So, I didn't have to go through that process." (ID 46, age 34) |
| Familiarity and trust in primary care system | Existing relationships and familiarity within one's primary care system made participants feel more comfortable navigating their abortion care. | #7 "Yeah, so prior to my first pregnancy, [my primary care doctor is] who I see for everything. So I didn't have to worry about finding new doctors for anything. She's who I go to." (ID 48, age 31)<br>#8 "I felt more comfortable because I've been here for a minute, it's not my first pregnancy scare [with this clinic], so I knew that I could trust in them and rely on them." (ID 33, age 26)<br>#9 "I've always had my PCP [in the health system] and that's where I had my baby and got all my care around that pregnancy and had really great experiences." (ID 46, age 34) |

*continues*

CPC = crisis pregnancy center; PCP = primary care physician; teleMAB = telemedicine medication abortion.

Note: Fourteen Massachusetts women of reproductive age were interviewed in 2022. Excerpts have been edited for clarity.

**Table 1. Excerpts Illustrating Patient Experience With TeleMAB Within Primary Care** *(continued)*

| Theme | Description | Illustrative Quotes |
|---|---|---|
| **Advantages of telemedicine** | | |
| Flexibility over where and when to take the appointment | Telemedicine allowed participants to take appointments in places and times that fit into their lives, reducing logistical, financial, health, and time-related burdens. | #10 "The televisit is convenient. It saves you time to move around. For instance, I have kids, so honestly, everywhere I will be going, I will be going with them, because I have no one to stay with them… And also the transport fare. I don't drive, so I have to transport myself to the hospital. Then the stress of looking after the kids, while I, at the same time, see the doctor, and all the examination processes. So [telemedicine] was quite convenient for me." (ID 53, age 34)<br>#11 "It was fine. It was actually a slow day [at work], so thankfully I was able to talk to my doctor and get everything that I needed… I had my headphones in so nobody really got to hear the conversation. I was able to answer the questions that needed to be answered, and just be able to take those next four steps." (ID 33, age 26)<br>#12 "They gave me the option of going to the clinic or having the appointment over the phone and I felt really comfortable doing it over the phone." (ID 3, age 28) |
| Autonomy and control | Telemedicine options afforded participants greater autonomy and control over their space, emotions, and overall experience. They felt more comfortable taking care of their needs in the comfort of their homes. | #13 "I was actually really sick during that pregnancy. I was vomiting the whole time up until the end of the abortion. So that was definitely a plus of not having to leave the house and be able to be in the comfort of my home and have the visits there" (ID 10, age unknown).<br>#14 "You could just be transparent and bare and not have to worry about being stripped in front of someone…Having done both, I would go virtual again a billion times over… I was able to be more free with [my clinician]… And I could light a cigarette or if I needed to pace around or move or get ice water or anything, it was all at my disposal right there… They gave me control of a situation that was uncontrollable to me and was freaking me out … I felt very in the driver's seat." (ID 9, age 32) |
| **Primary care normalizes abortion care** | | |
| Continuity of care | Participants felt more comfortable having abortion care in the primary care setting because their provider knew them and their needs and could take care of them in the full context of their health and social histories. | #15 "Yes, I like [abortion services provided at a primary care center]. It's a great clinic, where you can get treatment for everything. It's nice. It's because when you see an abortion clinic, it feels like a strange place. A place dedicated to abortions. It sounds strange. However, when it's a hospital where they treat all kinds of diseases and offer many treatments, it sounds better." (ID 15, age 31) |
| Primary care as a protective force | Participants felt their primary care providers helped reduce feelings of isolation, affirm their decisions, and mitigate difficult situations. | #16 "I'm a very traumatized person. I had a lot of childhood trauma and they just put ease in my life for the first time. I was just so appreciative. Because kindness isn't owed to you, it's something given as a gift… [the clinician] didn't have judgment on me." (ID 9, age 32)<br>#17 "I didn't know that it was going to go so bad… but I kept my cries in and I was able to talk to [the primary care doctor] about it. I just told him that I totally appreciate him being there for me because, besides the boyfriend, I had nobody else that I could speak to about everything that I went through." (ID 54, age 33)<br>#18 "I was being pressured (by the CPC) to make a different decision than what I came here for, but they want to try to tell me that they understand me and that they feel my emotion. You don't feel my emotion or understand my decision, if you're trying to force me to do something that I've even planned to come here to do." (ID 33, age 26) |

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Note: Fourteen Massachusetts women of reproductive age were interviewed in 2022. Excerpts have been edited for clarity.

medications] came at the time and date that it was supposed to come" (ID 10, age unknown). When asked what one participant liked about the delivery service, they responded, "All I had to do was just sit back at home and wait. It was great. It was the best part" (ID 15, age 31).

Existing relationships within the participants' primary care network made them feel comfortable navigating their care. While some participants were cared for by their own primary care physicians (PCPs), many participants received care by providers who were not necessarily their primary care doctor. Their trust extended from their provider to the health system. Participants felt more comfortable reaching out to their primary care network than to unfamiliar abortion clinics (Table 1, #6). While some felt comfortable asking their provider about pregnancy options because of existing relationships (Table 1, 7), others knew the health system provided abortion from prior pregnancy experiences (Table 1, #8 & #9). Despite being cared for by multiple

individuals—administrative staff, nurses, and physicians—participants described smooth transitions of care.

### Advantages of Telemedicine

Participants discussed how TeleMAB supported their ability to exercise control, autonomy, and flexibility (Table 1). In particular, patients described decreased interruptions to their daily lives, increased agency over their chosen surroundings and access to preferred coping mechanisms. For example, one participant shared that they completed their appointment while at work. Another participant noted a sense of agency by having their appointment at their desired location. One participant felt too sick from pregnancy symptoms to travel and valued staying home during the appointment. One shared, "It just made it an overall easy experience, and I didn't even have to go to my doctor for this. I'm doing this in my own time, my own energy, in my own home" (ID 33, age 26). Being in their own space gave participants greater access to coping strategies that helped decrease their anxiety and helped them feel safer expressing emotions and private information, "I could be a lot more vulnerable because I was right in my bed. And then you didn't have to worry about crying or wiping your face up and seeing people after that. Or people overhearing you in the office or something. You were just at home so you could just be like… this is worrying me" (ID 9, age 32).

### Primary Care Normalizes Abortion Care

Many participants perceived their primary care system as the place to go for pregnancy-related needs, including abortion. Their first instinct when they missed their period was "to call [their] PCP" (ID 54, age 33). Participants felt abortion should be part of routine primary care, whereas an independent abortion clinic seemed more isolating and "strange." Participants felt comfortable knowing that their abortion providers had access to their medical histories: "It was just comforting knowing I know the person [doing the abortion care] and we've seen each other multiple times before and she knows a little bit of my history and what I was going through at the time, so we had a good relationship as far as communication" (ID 10, age unknown). Another participant shared how their physician considered their history of gastrointestinal issues and the potential interaction of their chronic medications, noting, "she actually probably saved me from an overdose, too" (ID 9, age 32). They appreciated that their provider delivered care in the full context of their health and social needs.

Although complications from MABs are extremely rare, when medical or social challenges did arise participants reported their PCPs helped assuage difficult situations (Table 1). One participant had excessive bleeding after taking the medications and visited the emergency department, but felt relieved to talk to their PCP throughout the complication. Another participant inadvertently initially visited a crisis pregnancy center where they felt pressured to continue the pregnancy despite being certain about wanting an abortion. They subsequently had an overall affirming abortion experience with their PCP, however, as "I feel like my doctor did a really good job of giving me my options, but also giving me the opportunity to choose what I want to do, regardless of what they believe or regardless of what they feel is right," highlighting the importance of a trusted PCP relationship as a protective force in difficult situations (ID 33, age 26).

## DISCUSSION

Overall, participants who received TeleMABs within their primary care health system appreciated the ease of process, clear communication, non-judgmental interactions, continuity of care, and familiarity and trust with the system. Participants' TeleMAB experience contributed to increased feelings of autonomy, flexibility, and comfort. Participants noted a positive experience regardless of whether their PCP or another primary care clinician within the health system provided abortion care, but when difficult situations arose, established relationships with one's PCP helped mitigate the impact. Our findings highlight the ability of a primary care system to provide safe and positive abortion experiences in a high-quality, patient-centered way.

The more abortion is integrated into routine health care, the more normalized it becomes.[39] In our study, participants highlighted how familiarity with the system, ongoing patient-provider relationships, and being cared for in the context of their overall health made the abortion process more normal. Prior studies have found that providing emotional support and having a supportive patient-provider relationship reduces individual-level abortion stigma.[40] Though further research is needed on the link between normalizing care and decreasing stigma, we hypothesize that the factors found in our study which are unique to primary care may also destigmatize abortion care.

Although first trimester abortion care falls within the skill set of PCPs, significant barriers to providing abortion services remain. Barriers include limited abortion education within clinical training, policy restrictions limiting its provision in Federally Qualified Health Centers, onerous regulations around mifepristone prescribing, and state-level abortion bans.[41-43] There are limitations of implementing new abortion care models in states with complete bans. In states where access is protected or with limited restrictions, however, primary care systems can increase abortion access by implementing TeleMAB services, restructuring pay scale and reimbursement models, and partnering with abortion funds. In states where abortion bans exist, primary care providers can advocate with their state legislatures to remove state-level abortion restrictions.

Our study has several limitations. Because we interviewed participants 4 to 22 months after receiving TeleMAB (average of 7.7), our findings may be susceptible to limited recall. Our findings may reflect more positive patient experiences as people with negative experiences may have been less

willing to participate. Our patient population resided in Massachusetts, a state with better abortion access compared with other states, decreasing its generalizability.[44] Additionally, the majority of patients were English speaking, which may have biased our findings toward the English-speaking subgroup. We did not track if the participants received TeleMAB from their regular PCPs or whether appointments were via telephone or video. Future research could explore primary care patients' experiences prospectively, in more languages, telehealth modality, and with a larger sample size to address these limitations. While we hypothesize that integrating TeleMAB into primary care would increase abortion equity particularly for historically marginalized populations who have experienced racism and discrimination within medicine, this should be investigated further in future research.[45]

Findings from our study support primary care clinicians in advocating for TeleMAB implementation in ways that best address patients' needs. Since primary care clinicians vastly outnumber obstetrician-gynecologists in the United States and are more likely to practice in underserved and rural communities, barriers must be addressed to increase access and improve patient experience. Ultimately, a collaborative effort across state Departments of Health, primary care practices, and reproductive rights and justice organizations is needed to begin dismantling barriers to primary care provision of MAB, increasing access to care for millions.[46]

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**Key words:** abortion; telemedicine; primary care; patient experience; acceptability; normalize; access

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**Supplemental materials**

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