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Abortion-related attitudes and practice among physicians in New Mexico: has medical abortion increased access?

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Abortion-related attitudes and practice among physicians in New Mexico: has medical abortion increased access? Espey E\*, Ogburn T\*, Leeman L\*\*, Eyman C\*\*\*, Diaz M\*, \*The University of New Mexico (UNM) Hospital Department of OB/GYN \*\*UNM Hospital Department of Family Medicine, \*\*\*UNM School of Medicine, Albuquerque, NM

**Objective:** Although New Mexico does not have some of the harsh restrictions imposed on abortion found in other states, but access is still limited due to the lack of providers. Another study was conducted in 2001, just after FDA approval of medical abortion with mifepristone. This follow-up study aims to examine whether access to abortion in New Mexico has changed since the approval and to identify the current demographics of abortion providers, attitudes about abortion, and barriers to providing terminations. **Methods:** A self-administered questionnaire was mailed to all OB/GYNs and an equivalent number of randomly selected family physicians currently practicing in New Mexico. Questions assessed demographics and attitudes toward abortion. A sample size of N=400 was projected to provide a power of 80% and detect a 15% difference ( $\alpha=.05$ ) with a response rate of 50%. Data was analyzed utilizing Chi square. **Results:** Family practice and OB/GYN providers' attitudes and practice patterns are similar to those observed in 2001. Twenty-two abortion providers were identified (3 FP and 19 OB/GYN) similar to data in 2001. Statistically significant barriers for family practice physicians remain lack of training, lack of ultrasound equipment/experience, and concern for complications with lack of surgical backup. OB/GYNs cite personal belief as their primary barrier. There has been an increase in the number of providers of medical abortion in the state since the FDA approval of mifepristone ( $p=0.0397$ ). Approximately 16% of respondents received CME in the use of mifepristone since 2000. **Conclusion:** This study provided insight into the current practices and barriers to providing abortion in New Mexico. We recommend continued efforts to increase access to abortion training in residencies, increased awareness about abortion to ensure that patients are receiving accurate information and appropriate referral, and continued allocation of resources to provide CME training in mifepristone.

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## Introduction:

Abortion is currently one of the safest and most commonly practiced surgical procedures, with 1.2 million terminations being performed in the United States in 2005 and less than 0.3% having complications serious enough to require hospitalization.<sup>1</sup> Yet, despite the widespread need and impressive safety profile, there exists a marked shortage of providers and significant barriers to access for a large portion of American women. Currently, more than one fifth of pregnancies and 40% of unintended pregnancies in the United States end in abortion, making surgical abortion one of the most common medical procedures for women of reproductive age. At the current rate, studies performed by the Guttmacher Institute suggest that 35% of American women will have an abortion by the age of 45. Despite the obvious need for providers, 87% of American counties do not have providers who perform any kind of pregnancy termination services.<sup>2(p58)</sup> Those that do are most often located in the dedicated clinic and hospital setting and are not widely available in the private practice setting or outside dense urban centers.<sup>3(p104)</sup> As most providers are located in urban areas, 97% of all non-metropolitan counties do not have a single physician who offers abortion in their practice.<sup>4(p14)</sup> In addition, the number of abortion providers has decreased significantly since 1982, leading to a dramatic shortage.<sup>5(p200)</sup> In 2000, there were an estimated 1,819 abortion providers in the United States, a 37% decrease compared to the number of providers practicing twenty years earlier. Newer studies reveal another 2% decrease between 2000 and 2005.<sup>1</sup> Of those providers left still performing abortions, over 50% are at least fifty years of age, which will only lead to a further decline in the availability of providers in the future if new physicians do not start coming forward.<sup>2(p58)</sup>

## Abortion in New Mexico:

The trends in abortion provider demographics are all too familiar to New Mexicans

seeking abortions. Despite New Mexico's relatively liberal abortion laws, New Mexicans still have limited access to abortion. New Mexico is one of only 17 states that mandates state Medicaid funding for subsidy of abortions.<sup>1</sup> Additionally, our state constitution protects a women's right to reproductive health care with more fervor than even the Supreme Court's landmark decision in *Roe v Wade*. When addressing state funding of abortions the New Mexico court found that it was unconstitutional and in violation of the state's Equal Rights Amendment to ban access to certain medical care when the same restrictions could not be applied to men.<sup>6</sup> However, in 2005 only 12 physicians were identified as being active providers of abortion in the state of New Mexico.<sup>7</sup> These few providers are located in only three different counties and exist almost exclusively in metropolitan areas. Over 88% of counties in the state do not have abortion providers. Therefore, over 47% of New Mexican women live in a county that lacks abortion services and women must travel great distances to receive the care they need.

#### An Issue of Access:

This alarming downward trend in the number of providers directly impacts general access to reproductive health options for many women in America today.<sup>8</sup> Yet, in this critical time of decreased abortion providers, there is decidedly limited information available regarding physicians attitudes on abortion services and what impacts their decisions about whether or not to provide pregnancy termination services. Many factors may contribute to this change including stringent restrictions placed on the physician in regards to their own medical and business practices, spiritual and religious beliefs, limited access to training, fear of personal safety, and lack of a perceived need. Due to the complex political debate that heats all discussions of abortion, a woman's choices regarding reproductive health have been limited legally throughout the last thirty years (parental notification, building requirements, and access to emergency

surgical services).<sup>9(p105)</sup> Since the *Roe v Wade* decision, many smaller court battles have placed restrictions on abortions that severely hinder the availability of some services.<sup>1</sup> In addition, while physicians are expected to remain impartial participants in the advisement of patients' health related issues, each physician is also a private citizen with their own religious, moral, and ethical background and the "freedom to choose his or her mode of practice and which services to provide."<sup>10</sup> The physician may also take into account the feelings of other staff members, the facility they work in, or the greater community as a whole. Most tragically, physicians must also contend with the possibility of physical threat, professional ostracism, and emotional exhaustion.<sup>9(p105,108)</sup> Another contributing factor that is gaining recognition nationally is a lack of training. Abortion training among obstetric-gynecology residencies decreased significantly between 1985 and 1992.<sup>11(p39,e1)</sup> This decrease in training corresponds directly with a subsequent decrease in providers between 1992 and 2000. A recent study of family practice residencies found that only eleven programs out of a 480 wished to be self-identified as providing abortion curriculum.<sup>12</sup> This decrease comes despite recent studies that show offering training as a routine part of education in both residency and medical school increases the chance that a trainee will go on to provide abortions in practice.<sup>13</sup> Any attempt to increase the number of abortion providers must first address to what degree issues and/or training related or other personal/professional factors, affect a physician's willingness in providing those services.

#### New Options: Medical Abortion

On September 28, 2000 the FDA approved the use of mifepristone as an abortifacient.<sup>4(p104)</sup> Mifepristone is a pharmaceutical able to induce pregnancy termination by acting as a competitive inhibitor of progesterone receptors through a decrease in the actual number of available progesterone receptors.<sup>15</sup> The decrease in stimulus to the decidua by

progesterone causes the endometrial lining to degenerate and shed. It is often given in conjunction with misoprostol to initiate uterine contractions. The FDA approval of mifepristone for medical abortion in the United States marked a new wave of reproductive health choices for women seeking to terminate a pregnancy. This method provides options for women who would prefer a non-surgical abortion or one that seems more private or natural.<sup>3(p104)</sup> In addition to having benefits to patients, the advent of medical abortion may afford practicing physicians more options in deciding what services to offer.<sup>16</sup> Although medical abortion does have some drawbacks and is limited by many of the same barriers as surgical abortion, it has been speculated that the availability of this new, less invasive method "potentially could decentralize the provision of abortion, increase the number, types and geographic distribution of providers and thereby reduce other barriers such as antiabortion picketing and clinic violence."<sup>3(p104)</sup> Just after the FDA approval in early 2001, mifepristone was thought to account for only 6% of all abortions nationwide.<sup>4(p6)</sup> One goal of this project is to uncover whether mifepristone has increased access to abortion in New Mexico since that time.

#### Study Background:

In 2001 a similar project was conducted to address physician attitudes toward abortion in New Mexico.<sup>17</sup> It aimed to identify physician-specific factors that influence attitudes and affect access to abortion services. In addition, the study inquired as to whether physicians would be interested in training in the use of mifepristone as a medical abortifacient to be integrated into their practices. The study was conducted by sending a 23-question survey to New Mexico physicians including both family practice and obstetric-gynecology doctors. Of the 400 surveys sent a total of 226 were returned, yielding a response rate of 56%. The study analyzed the demographics of responding physicians including type of practice, setting, age, and length of

practice. A total of 22 abortion providers were identified.

In answering the question "why don't more physicians provide abortion?" the two most common reasons given for either medical or surgical abortion were "personal, moral and religious beliefs" not allowing for abortion, and a lack of training in abortion services.<sup>17</sup> It was also found that men were more likely to cite "personal, moral, and religious beliefs" as barriers to providing these services ( $p=0.024/<0.006$ ). Women were more likely than men to cite "lack of training in ultrasound technique" and lack of availability of equipment as obstacles ( $p=0.018/0.017$  and  $p=0.016/<0.001$ ). Women were also more likely than men to cite issues of "practice setting restrictions against providing abortions" in regards to surgical abortion and "concern for safety" for both surgical abortion and medical abortion ( $p=0.033$  and  $p=0.011/p=0.004$ ).

In analyzing the differences between specialty type, it was discovered that OB/GYNs were more likely to cite "personal, religious or moral beliefs against surgical abortion" than were FPs ( $p=0.003$ ), but not for medical abortion services.<sup>17</sup> Family physicians were more likely to cite "no perceived need" than were OB/GYNs ( $p=0.004$ ). In addition, FPs were more likely to address reasons pertaining to training and equipment ( $p=<0.001$ ).

The study further delved into the exact attitudes of physicians regarding abortion by providing various scenarios for possible pregnancy termination and having physicians grade their agreement/disagreement with each of the five situations: for a diagnosis of Trisomy 21, for a lethal fetal anomaly, to preserve the life/health of the mother, in the case of rape/incest, and patient request.<sup>17</sup> The responses were given a rating of 0-3 and each scenario's mean response was determined. The means for all five scenarios were greater than two, leading to a conclusion that New Mexico physicians generally agree with both elective and therapeutic abortion.



Significant differences, however, did exist when comparing these responses among various demographic and practice populations.

Question:

This project will be a continuation of the previous 2001 study conducted to uncover trends in the practice of abortion in the state of New Mexico. This study and its predecessor in 2001 seek to uncover the demographics of existing abortion providers, the barriers keeping physicians from offering the full range of reproductive health services, and any change that has taken place within New Mexico since the FDA approval of mifepristone in 2000. As this is a follow-up study, there will be investigation into changing trends, especially regarding new provision and training in medical abortion and how this has changed access to reproductive health options for New Mexican patients.

Methods:

A self-administered, computer-scannable questionnaire consisting of 23 questions was sent out to family physicians and OB/GYNs in New Mexico to assess demographic information, attitudes toward abortion, and abortion practice patterns (See Appendix 1). The survey underwent rigorous modification for readability and content by a small focus group during the initial trial and again was taken to a small focus group of medical students after small changes were made for this round of distribution. The survey took approximately 10 minutes to complete and was approved by the UNM HRRC. Names and contact information for the physicians surveyed was obtained from the New Mexico branch of the American Medical Association. The surveys were accompanied by a letter explaining confidentiality and the nature of the study as well as a post-paid envelope for return mail (See Appendix 2). After approximately six weeks a reminder postcard was sent to those physicians who had not responded. Effort was taken to

ensure the correct addresses by performing exhaustive internet searches for contact information with subsequent follow-up calls. If information was obtained during this search that revealed a physician had moved out of the state, retired, or was deceased, they were excluded from the sample. All data linking participants to their responses and the returned completed surveys were kept securely in the possession of only those researchers involved in data analysis.

In order to be included in this study, a participant had to be a practicing family practice or OB/GYN physician in the state of New Mexico. In addition to the above parameters, certain exclusion criteria were set. Those physicians known or reporting to only practice OB/GYN in the context of oncology or REI (Reproduction, Endocrinology and Infertility) were excluded, as abortion would typically fall well outside their scope of practice.

A sample size of N=400 was projected to provide a power of 80% and detect a 15% difference ( $\alpha=0.05$ ) if the response rate was at least 50%. The specific outcomes of the study were suitable for proportion chi-square analysis. The study was conducted using a p-value of  $p=0.05$ . A confidence interval was calculated and the chi-square test was used to compare the proportions where appropriate. Responses were also examined for frequency reporting information in regards to current practice patterns and perceptions about abortions. Analysis of some survey questions was conducted to compare answers of obstetric-gynecologists versus family medicine physicians as well as male versus female respondents. In addition to comparisons within groups, analysis was also conducted comparing the 2007 findings to that of the 2001 study.

### Results:

Demographics: This study achieved an overall response rate of 41.4%. The respondents were more largely represented by OB/GYNs, 59% compared with 41% family physicians. OB/GYN's

were more likely to respond to the survey, achieving a response rate of 53% compared to a rate of 32% among family medicine physicians ( $p=0.0029$ ). Men and women were represented similarly with 53% and 47% respectively. The most common age group for respondents was between 51-60 and the most common response for time in practice was between 21-30 years. The majority of returned surveys came from physicians in urban areas, 72% as compared to 28% responding from rural areas. The most common practice setting was private practice (50.76%).

Current Practice Pattern of Abortion Providers: A total of twenty-two abortion providers were identified, 16% of the total respondents. Fifteen (68%) of the identified providers offered medical abortion, which is equal to the number who offered surgical abortion. Men and women who responded to our study perform abortion and a roughly equivalent rate, 19% of women and 14% of men ( $p=0.6203$  – See graph 1.1). The age and years in practice for those identified as providers did not differ significantly from that of the overall respondents (See Graphs 1.2 and 1.3). All but one of the twenty-two abortion providers practice in an urban setting (See Graph 1.4). This is notable, especially when considering that despite the fact that our sample had a high number of respondents from urban areas, 34% reported that patients in their practice would have to travel more than fifty miles to receive abortion services. Another notable area of comparison among providers of abortion was specialty (See Graph 1.5 and Table 1). OB/GYNs were more likely to offer abortion overall, 24% compared to 5% of family physicians, and also more likely to offer surgical abortion, 18% compared to 2% ( $p=0.0149$  and  $p=0.0134$ ). However, due to the small number of providers, the difference between obstetric-gynecologists and family physicians who offer medical abortion, 15% and 5% respectively, was not statistically significant ( $p=.1537$ ). OB/GYNs were also more likely to have referred a patient to another provider than their family physician counterparts ( $p=0.0016$ ). As might have been expected, obstetric-gynecology

physicians were more likely than family medicine doctors to have received training in abortion as part of their residency ( $p=0.0163$ ).

In comparing the 2008 survey to the 2001 survey, we found some changes in abortion access in New Mexico (See Table 2). There has been a significant increase in the number of providers of medical abortion in the state since the FDA approval of mifepristone ( $p=0.0397$ ). Approximately 16% of respondents indicated having received CME (Continuing Medical Education) in the use of mifepristone since 2000. Conversely, there was a decrease in the number of respondents interested in receiving training in the future from those who were interested in 2001 ( $p<.0001$ ).

Barriers: In order to evaluate possible barriers to providing abortions in practice, those surveyed who did not currently provide abortion were given a list of possible barriers and asked to indicate which reasons, if any, contributed to their decision. The top two reasons cited for surgical abortion were 1) “personal religious, or moral belief against abortion” and 2) “lack of training in surgical abortion techniques.” In analyzing the role that gender plays in the decision of whether or not to provide abortion, women and men were not found to differ greatly, although, women were more likely to have concerns about personal safety than men specifically related to providing surgical abortion ( $p=0.0324$ ). When looking only at medical abortion, men were more likely to cite personal belief as a reason to not provide ( $p=0.0122$ ).

Analysis was also conducted to compare respondents by specialty in relation to the reasons that physicians do not provide abortion (See Table 3). Among obstetric-gynecologists the most common reason provided for not performing abortion was “person, religious, or moral beliefs.” This was of greater importance to OB/GYNs when compared to family physicians ( $p=0.0143$ ). Family physicians’ number one barrier was a “lack of training in surgical abortion

techniques.” Sixty-five percent of family physicians cited this reason compared to only 15% of OB/GYNs ( $p < 0.0001$ ). Family medicine physicians were also more likely to cite “lack of experience in obstetrical ultrasound technique” or a lack of ultrasound equipment in the office as a significant barrier for both medical and surgical abortions than OB/GYNs ( $p < 0.0001 / < 0.001$  and  $p < 0.0001 / < 0.0001$ ).

When specifically addressing issues surrounding the provision of medical abortion, family medicine doctors were more likely to cite “lack of training in use of mifepristone” ( $p = 0.0013$ ). Additionally 60% of family physicians, who typically have less surgical training cited concern for “lack of surgical back up,” compared to none of the OB/GYNs who responded ( $p < 0.0001$ ). Other barriers that were consistently cited among both groups included “staff attitudes against abortion,” “concern for safety,” and “practice setting restrictions.” Many respondents left comments explaining that that their facility did not allow abortions to be performed on site. Our sample did not exclude individuals that worked at facilities with these self-imposed restrictions or those who work for government agencies where abortion is prohibited.

Physicians Attitudes: In an effort to assess attitudes about abortion, physicians were asked whether they agreed or disagreed with a woman receiving an abortion in five different scenarios: for a pregnancy resulting from rape/incest, to preserve life/health of the mother, for fetal anomaly incompatible with life, for a diagnosis of Trisomy 21, or for patient request. Respondents were able to choose from the following options: strongly disagree, somewhat disagree, somewhat agree, or strongly agree. When comparing attitudes between subgroups, these gradations were combined into only agree and disagree. Overall respondents agreed with abortion in all of the scenarios. For rape/incest 89% of respondents agreed that a woman should

be able to terminate her pregnancy. For the health/life of the mother and a fetal anomaly incompatible with life >90% of respondents agreed and for a diagnosis of Trisomy 21 or patient request still >75% of physicians surveyed agreed that abortion was a suitable option.

There were, however, interesting differences and similarities among different subgroups. Of the five situations listed in the attitude portion of the questionnaire males and females only diverged on one. Eighty-eight percent of women agreed with termination upon patient request as compared with only 62% of men ( $p=0.0004$ ). When evaluated by specialty, OB/GYN's and family physicians differed only in their agreement of performing abortion for fetal anomaly incompatible with life, 97% of OB/GYNs agreeing versus 89% of FPs ( $p=0.0430$ ). This difference is consistent with data collected in the 2001 survey. Data was also analyzed to compare those respondents who identified themselves as abortion providers and those that did not. Interestingly, no statistically significant difference was found between providers of abortion and non-providers in any of the given scenarios. This may be due in part to the small number of providers in our sample.

#### Discussion:

Given the initial sample size was smaller than the anticipated 400 and that our response rate is currently lower than expected, our study does not currently achieve the projected 80% power. Although significant trends were found and data was largely consistent with the results of the unpublished 2001 study, the small sample size and less than expected response rate are weaknesses of this study. Other interfering variables might be bias due to self-selection of the respondents versus non-respondents, bias due to the sensitive topic and issues surrounding confidentiality. Although respondents were assured that all reasonable measures would be taken to protect their anonymity, some abortion providers might still be concerned about unwanted

attention or retribution if their answers were shared. Also, on the third attempt to contact individuals, the internet was used to search for names, addresses, and phone numbers. It is possible that this process might in some way skew the data if, for example, rural providers were less likely to have their contact information posted on the internet. Attention should also be paid to the fact that our study included only family physicians and obstetric-gynecologists in New Mexico. There are general practitioners, physicians from other specialties, as well as physicians from out of state who travel to provide abortions in New Mexico who were not surveyed under our inclusion criteria. Therefore, the presented data may underestimate the total number of physicians who provide abortion in the state.

In examining current abortion practices in the state, our results identified twenty-two current providers. While this number is larger than the Guttmacher Institute's estimate of 12, it is equal to the number of providers identified by the unpublished 2001 study.<sup>7,17</sup> However, since the FDA approval of mifepristone, the number of providers of medical abortion have increased significantly. There are now 15 providers of medical abortion in the state. While this number is still not adequate to eliminate problems with access to abortion in New Mexico, it is an important improvement. Additionally, it is encouraging that 16% of respondents have already received CME training and that another 32% are interested in receiving training in mifepristone in the future. Although the percentage of respondents that would like training has declined since 2001, this decrease is probably accounted for by the portion of providers that already received CME and the recent inclusion of mifepristone training into residency programs. Also, 9.5% of respondents who do not currently offer medical abortion in their practice indicated that they plan to at some point in the future. While this may not seem like a large portion, if this came to fruition, it would mean an additional ten providers in the New Mexico.

Another consideration among providers is the volume of abortions performed. Among those providers that offer surgical abortion, 45% report doing between 1-10 per year. This leaves five providers to perform the vast majority of terminations (answered >20 per year). The data is virtually identical for medical abortions, where still only five providers indicate performing more than twenty abortions per year.

The data did not uncover a significant difference between male and female providers and no statistical difference was found related to age or length of practice. However, specialty was a deciding factor. Only one of the fifty-six family medicine physicians who responded offers surgical abortion, compared to fourteen of the seventy-nine OB/GYNs ( $p=0.0134$ ). While the sample was not large enough to reveal a statistically significant difference, OB/GYNs remained more likely than FPs to offer medical abortion (15% versus 5%,  $p=0.1537$ ). Family physicians were also significantly less likely to refer patients for an abortion (55% versus 80%,  $p=0.0016$ ). While this difference might be inflated by the fact that some FPs do not see pregnant patients or that patients may preferentially visit an OB/GYN when seeking termination, it is still a disparity that warrants further examination. In trying to increase access, effort must be focused not only on creating more providers, but also on increasing awareness about abortion in general to ensure that patients are being appropriately referred when necessary.

A barrier of growing interest in other studies dealing with abortion is a lack of training. It is understandable that if a physician has access to training during residency they will be more likely to offer such service in future practice. Our study reveals the same concerning trend found throughout the country. Despite the fact that abortion is one of the safest and most commonly performed surgical procedures, it is not necessarily viewed as a routine part of training.<sup>1</sup> This is even true in New Mexico where the only family medicine and OB/GYN residency programs



include abortion training in the curriculum. Even in New Mexico only 62% of practicing OB/GYNs and only 42% of family medicine physicians received training ( $p=0.0163$ ). Clearly one must conclude that efforts to increase access to abortion for female patients must focus on increasing access to education for their physicians.

Respondents in our study also cited barriers including “person, religious, or moral belief against abortion,” especially among OB/GYNs, and lack of training either in ultrasound, surgical, or medical abortion, specifically among family medicine physicians. While it is important to acknowledge the controversial nature of this topic and to make abortion something that is more widely discussed and understood, it is unlikely that any effort undertaken to do so could quickly change individual or societal beliefs about abortion. Therefore, this again points toward education as the primary target for reform. In considering that 25% of OB/GYNs who responded to our survey already provide abortion and that another 45% have concerns related to their personal beliefs that prohibit them from offering terminations, one must consider the possibility that the answer to increasing the number of providers of abortion is not obstetric-gynecologists, but rather family physicians who currently receive less abortion education and cite this as their number one reason for not providing. It is also possible, though outside the scope of our data, that targeting education in other specialties (e.g. surgery, internal medicine, pediatrics) and their respective residency programs might also improve access.

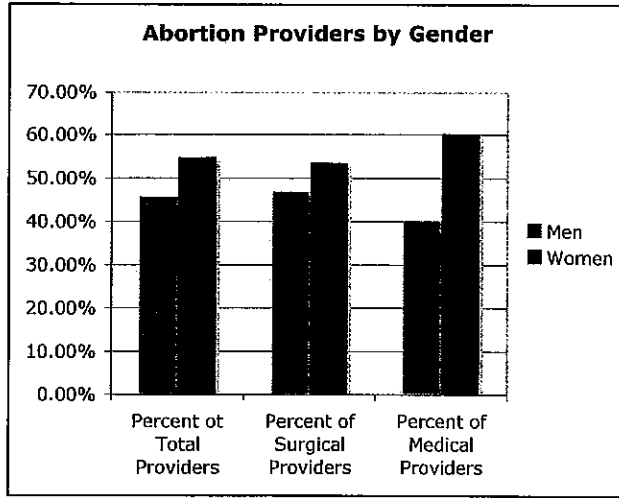
A final area of interest was physician attitudes toward abortion, as they have been shown nationally to have a significant effect on physicians’ decision about whether or not to provide terminations. Physicians in this study were overall overwhelmingly supportive of a woman seeking abortion in each of the scenarios outlined in our survey. Women were more likely than men to support providing abortion for “patient request” and OB/GYNs were more likely than

FPs to favor offering services in cases of “fetal anomaly incompatible with life.” Interestingly, there was not a significant difference among any of the cases between those who provide and do not provide abortion, showing that overall New Mexico physicians favor access to abortion whether or not they provide the service. While this area of study is certainly illuminating and interesting from a sociological standpoint, it is unlikely that further study would be likely to influence access since the results are relatively analogous between subgroups.

In conclusion, this study provided insight into the current practices and barriers to providing abortion in New Mexico that may potentially be applicable in efforts to increasing access to abortion. Based on the above results we recommend continuing efforts to increase access to abortion training in OB/GYN residencies and further targeting of family practice residencies whose physicians are being underutilized in offering abortion at this time due to lack of training. We recommend efforts be taken to increase awareness about the safety and frequency of abortion procedures as well as where services can be received in New Mexico to ensure that patients are receiving accurate information and appropriate referral. Due to the increase in the number of providers of mifepristone and its relative ease of use in practice, we recommend continuing to allocate resources to provide CME training. Also, as there is a shortage of providers in rural areas, this group might be the most beneficial to target not only to increase the number of providers, but also to decrease the distance that patients must travel to receive terminations.

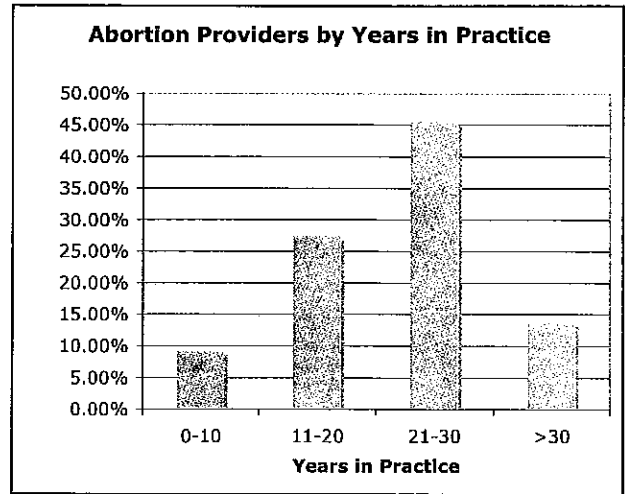
Tables & Graphs:

Graph 1.1



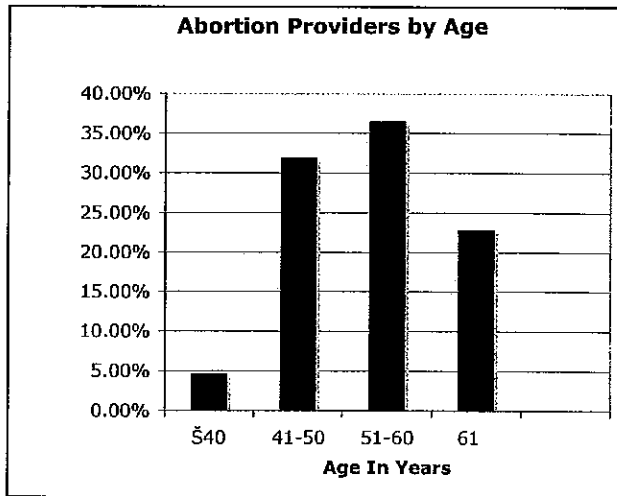
Graph 1.1 – Percentage of respondents by gender that offer abortion in practice. There is no statistical difference in provision of abortion among physicians of different gender (p=0.6203, p=0.8167 and p=0.4676 respectively).

Graph 1.3



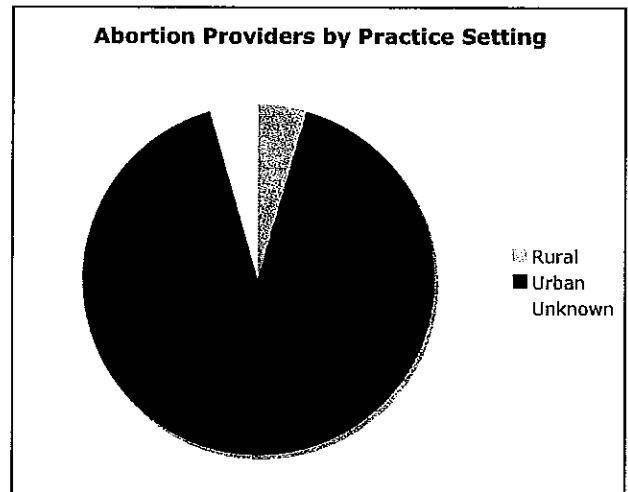
Graph 1.3 – Percentage of abortion providers by years in practice. There is no significant difference from our general respondent pool (p=0.7760)

Graph 1.2



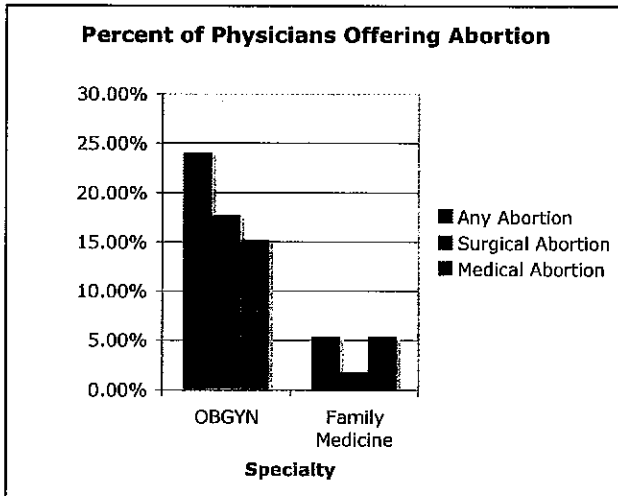
Graph 1.2 – Percentage of respondents by age that offer abortion. There is no statistical difference in our general respondent pool and those who provide abortion (p=0.7393).

Graph 1.4



Graph 1.4 – Abortion providers by practice area. Abortion providers are disproportionately located in urban areas (p=0.0353).

Graph 1.5



Graph 1.5 Percentage of providers by specialty that offer surgical/medical abortion (p= 0.0149, p=0.0134, p=0.1537\*). The difference between OB/GYNs and family physicians that provide medical abortion is not statistically significant based on our sample size.

Table 1

Changing Trends: 2008 vs 2001 Survey Response Data			
	2008 Data	2001 Data	p-value
Provide Surgical Abortion	11.11%	6.22%	0.3613
Provide Medical Abortion	11.11%	4.55%	0.0397
Received abortion training during residency	54.2%	52.91%	0.8176
Interested In Training to Provide mifepristone	32.17%	55.83%	<0.0001

Table 2

Differences Between Specialties: OB/GYN vs. Family Medicine			
	OB/GYN (n=79)	Family (n=56)	p-value
Has referred patient for an abortion in the last year	80.26%	54.55%	0.0016
Received abortion training during residency	62.82%	41.51%	0.0163
Interested in Training To Provide mifepristone	25.81%	39.62%	0.1139

Table 3

REASONS FOR NOT PROVIDING SURGICAL ABORTION			
	<b>OB/GYN</b> (n=60)	<b>Family</b> (n=53)	<b>p-value</b>
Personal, religious, or moral belief against abortion	54.84%	32.08%	0.0143
Lack of training in surgical abortion techniques	15.25%	65.31%	< 0.0001
Lack of ultrasound in office	5.17%	53.06%	< 0.0001
Lack of experience in obstetrical ultrasound technique	3.45%	57.14%	< 0.0001
Office staff attitudes against abortion	20.69%	23.91%	0.694
Concern for safety (of self, family, office staff, etc.)	22.03%	22.22%	0.9817
Practice setting restrictions against providing abortions	41.38%	45.65%	0.6622

Table 4

REASONS FOR NOT PROVIDING MEDICAL ABORTION			
	<b>OB/GYN</b> (n=60)	<b>Family</b> (n=53)	<b>p-value</b>
Personal, religious, or moral belief against abortion	56.67%	34.78%	0.0253
Lack of training in use of mifepristone	32.73%	65.85%	0.0013
Lack of ultrasound in office	5.56%	48.78%	< 0.0001
Lack of experience in obstetrical ultrasound technique	7.41%	60.98%	< 0.0001
Office staff attitudes against abortion	26.42%	21.43%	0.5731
Concern for safety (of self, family, office staff, etc.)	20.75%	24.39%	0.6747
Lack of surgical back up	0.00%	60.00%	< 0.0001

Table 5

PHYSICIANS' APPROVAL OF ABORTION IN SPECIFIC CIRCUMSTANCES			
	<b>OB/GYN</b> (n=79)	<b>Family</b> (n=56)	<b>p-value</b>
Pregnancy resulting from rape or incest	91.03%	87.04%	0.4643
To preserve the life/health of mother	96.15%	94.34%	0.6259
Fetal anomaly incompatible with life	97.44%	88.89%	0.0430
Diagnosis of Trisomy 21	76.62%	75.93%	0.9263
Patient request	75.64%	74.07%	0.8380

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**Physician Survey**

- 1. Have you performed any **surgical** abortions in the last year?  Yes  No
- 2. In the last year, how many **surgical** abortions did you perform using D&C or MVA (manual vacuum aspiration)?  None  1-10  11-20  >20
- 3. Please indicate, using the scale below, how much each of the following factors influenced why you have not offered elective surgical abortions in the past year:

	<b>Not At All</b>	<b>Somewhat</b>	<b>Very Much</b>
a. Personal, religious, or moral belief against abortion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Lack of training in surgical abortion techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lack of ultrasound in office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Lack of experience in obstetrical ultrasound technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Community attitudes against abortion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Office staff attitudes against abortion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Concern for safety (of self, family, office staff, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Practice setting restrictions against providing abortions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. No perceived need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any other factors not listed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 4. In the past year, have you performed any **medical** abortions using **mifepristone** (RU486)?  Yes  No
- 5. In the past year, have you performed any **medical** abortions using **methotrexate**  Yes  No
- 6. In the past year, how many **medical** abortions did you perform using methotrexate or mifepristone?  None  1-10  11-20  >20
- 7. Do you anticipate incorporating mifepristone into your practice?  
 Already do  Never  Within 1 year  Yes, more than a year from now

8. Please indicate, using the scale below, how much each of the following factors influences why you are unsure about or do not plan on performing medication abortion in the next year:

	<b>Not at all</b>	<b>Somewhat</b>	<b>Very Much</b>
a. Personal, religious, or moral belief against abortion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Lack of training in use of mifepristone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lack of ultrasound in office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Lack of experience in obstetrical ultrasound technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Community attitudes against abortion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Patients' beliefs against abortion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Office staff attitudes against abortion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Concern for safety (of self, family, office staff, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. No perceived need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Lack of surgical back up (i.e. D&C if required)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Concern about side effects of mifepristone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any other factors not listed: \_\_\_\_\_

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9. In the past year, have you referred any pregnant women to other physicians for abortions?  Yes  No

10. How far from your practice is the nearest provider to whom you refer pregnant women for abortions?  <50 miles  50-100 miles  >100 miles  Unknown

11. At the end of your residency, did you feel you had sufficient training/experience to perform first trimester surgical abortions?  Yes  No

12. At the end of your residency, did you feel you had sufficient training/experience to perform first trimester medication abortions?  Yes  No

13. Please indicate how much you agree/disagree with a woman receiving an abortion in the following situations:

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
a. Pregnancy resulting from rape/incest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. To preserve life/health of the mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Fetal anomaly incompatible with life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Diagnosis of Trisomy 21	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Patient request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Have you received CME or hands-on training in the use of mifepristone for medical abortion since it was FDA approved in 2000.

15. If you have not, would you be interested in attending CME training in the use of mifepristone regimen for medical abortion if it were provided in your area?  Yes  No

**Please Answer Some Questions About Yourself:**

18. What is your area of specialty?

- Family Physician
- Obstetrician-Gynecologist

19. In what setting do you practice?

- Private Practice
- Military/IHS/VA
- Group/staff model HMO
- University/Academic
- Community Health Center
- Other (Please Specify) \_\_\_\_\_

20. What is your gender?

- Male
- Female

21. What is your age?

- <30

- 31-40
- 41-50
- 51-60
- 61-70
- 70+

22. How many years have you been in practice?

- 0-10 years
- 11-20 years
- 21-30 years
- >30 years

23. How would you describe the area in which you practice?

- Urban (pop. >30,000)
- Rural (pop. < 30,000)

**Thank you very much.**

## APPENDIX 2

Dear Physician:

Your views on abortion are important. Patients frequently have been surveyed about their attitudes and experiences of abortion, but physicians have rarely been surveyed. Abortion as a health issue is often overshadowed by abortion as a political issue. As investigators from the University of New Mexico, we hope to determine physician attitudes and practices specific to New Mexico.

This study will examine the attitudes and practices of approximately 400 family practice and OB/GYN physicians in New Mexico on the issue of abortion. Your participation is completely voluntary. In order to obtain complete and accurate information, however, please take the approximately 10 minutes necessary to complete the enclosed survey of your personal views and experiences on this controversial health issue. Your participation will provide new and valuable information.

You may be assured of complete confidentiality. Please do not place your name or other identifiers on the survey. Please return the completed survey in the self-addressed stamped envelope provided for you. We will not link your survey responses to your personal identity in reporting our study results. Only group responses will be reported. Linkage of the mailing list of physicians to individual surveys will be used only by the investigators, will be maintained in a locked filing cabinet and will be destroyed after the analysis of the data.

If you would like a copy of the results, please send your name and address under separate cover and we will send you a copy.

I have read and understand the informed consent and conditions of this study. I hereby acknowledge the above and give my voluntary consent to participate in this study. I understand I may withdraw at any time without penalty. I acknowledge that I am eighteen years of age or older. Submission of the completed survey is acknowledgement of my consent.

Thank you for your cooperation and participation.

Sincerely,

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