



Contents lists available at ScienceDirect

## Contraception

journal homepage: [www.elsevier.com/locate/contraception](http://www.elsevier.com/locate/contraception)

Original Research Article

# Barriers to abortion provision in primary care in New England, 2019–2020: A qualitative study<sup>☆,☆☆,★</sup>

Charlotte M. Lee<sup>a,\*,\*\*,\*</sup>, Sarah L. Johns<sup>b</sup>, Debra B. Stulberg<sup>c</sup>, Rebecca H. Allen<sup>a,d</sup>, Elizabeth Janiak<sup>b,e</sup>

<sup>a</sup> Warren Alpert Medical School of Brown University, Providence, RI, USA

<sup>b</sup> Brigham and Women's Hospital, Department of Obstetrics and Gynecology, Boston, MA, USA

<sup>c</sup> University of Chicago, Department of Family Medicine, Chicago, IL, USA

<sup>d</sup> Women and Infants Hospital, Department of Obstetrics and Gynecology, Providence, RI, USA

<sup>e</sup> Harvard Medical School, Boston, MA, USA

## ARTICLE INFO

## Article history:

Received 2 January 2022

Received in revised form 5 August 2022

Accepted 6 August 2022

## Keywords:

Abortion

Family medicine

Practice expansion

Primary care

Reproductive health

## ABSTRACT

**Objective:** To assess barriers to and facilitators of abortion provision among abortion-trained primary care providers.

**Study Design:** We conducted 21 qualitative in-depth interviews with 20 abortion-trained family physicians and one internal medicine physician in five New England states. We dual-coded interviews, using a consensus method to agree upon final coding schema. Through iterative dialogue, using an inductive content analysis approach, we synthesized the themes and identified patterns within each domain of inquiry.

**Results:** The most commonly reported barriers were a lack of organizational support, the Hyde Amendment, which prevents the use of federal funds for most abortion care, and the mifepristone Risk Evaluation and Mitigation Strategy, a federal regulation which prohibits routine mifepristone pharmacy dispensing. The logistical barriers created by these policies require cooperation from additional stakeholders, creating more opportunities for abortion stigma and moral opposition to arise. Other salient barriers included inter-specialty tension (particularly with obstetrician-gynecologists), perceived need for pre-abortion ultrasound, absence of a clinician support network, and lack of knowledge of existing resources for establishing abortion care in primary care.

**Conclusions:** Increased abortion provision in primary care is one of many necessary responses to the human rights crisis produced by the *Dobbs* decision. Eliminating the Hyde Amendment and ending federal regulations restricting pharmacy dispensing of mifepristone are key interventions to address barriers to primary care abortion provision. Building interspecialty partnerships between family medicine and OB/GYN and spreading awareness of the evidence-based ultrasound-as-needed protocol and other educational resources are also likely to increase primary care abortion access.

**Implications:** By exploring barriers to and facilitators of primary care abortion provision, this study outlines a targeted approach to support increased access to abortions. In states with legal abortion post-*Roe*, it is important that motivated and trained primary care providers can offer abortions, rather than referring patients to overburdened specialty clinics.

© 2022 The Authors. Published by Elsevier Inc.

This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>)

<sup>☆</sup> Conflicts of interest: The authors declare no conflict of interest.

<sup>☆☆</sup> Funding: This research was funded by the Society of Family Planning Emerging Scholars Grant and a Summer Research Fund from the Warren Alpert Medical School of Brown University Population Medicine Master's Program.

<sup>\*</sup> Declaration of Competing Interest: The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

<sup>\*</sup> Corresponding author.

E-mail address: [charlotte.m.lee@gmail.com](mailto:charlotte.m.lee@gmail.com) (C.M. Lee).

<sup>\*\*</sup> Since completion of this study, Dr. Lee's affiliation has changed to Tufts Medical Center Department of Obstetrics and Gynecology, 800 Washington St, Boston, MA, USA 02111.

## 1. Introduction

When access to safe abortion is restricted, reproductive autonomy is constrained and the health of entire communities suffers. This public health challenge disproportionately affects people with minoritized racial identities and people of lower income [1]. In June 2022, the Supreme Court of the United States handed down a decision in *Dobbs v Jackson Women's Health Organization*, which overturned the constitutional guarantee to pre-viability abortion established by the 1973 *Roe v Wade* case [2]. As a result, states may now strictly limit or completely outlaw abortion, and 26 states are anticipated to do so [3].

Integrating abortion into primary care is a promising strategy to improve access in states where abortion remains legal, but logistical obstacles can create access deserts. New England is a prime example of an area with supportive policies where access challenges nonetheless persist [4]. In New Hampshire, Vermont, and Rhode Island, most counties do not have an abortion clinic (60%, 64%, and 60% respectively); rural areas of Maine and the southeastern region of Massachusetts also lack abortion providers [5]. While the number of specialty abortion clinics is limited, particularly in rural areas, New England states (with the exception of Connecticut) have a surplus of primary care providers (PCPs) [6]. Thus, New England provides an ideal setting to analyze the potential for PCPs to fill critical gaps in abortion access. In areas like New England, PCPs are geographically easier for many patients to access compared to specialty abortion providers, and hold high potential for sustainability when abortion care is provided with full spectrum comprehensive primary care [7]. Additionally, prior research found that many patients would prefer to receive abortions with their PCPs [8,9].

Both family and internal medicine physicians, as well as advanced practice clinicians specializing in family or women's health, are well qualified to provide medication abortion [10,11]. However, the Risk Evaluation and Mitigation Strategy imposed by the US Food and Drug Administration on the drug mifepristone (hereafter, the mifepristone REMS) poses logistical barriers to abortion in primary care. Until December 2021, the mifepristone REMS required that the drug be dispensed only in a clinical setting by certified prescribers; though it can now be dispensed via mail and from certified pharmacies, mifepristone is still not routinely prescribed and cannot be ordered for pickup at a retail pharmacy.

In a national survey of internal medicine and family medicine PCPs, 5% reported providing an abortion post-residency [12]. However, more family medicine physician educators report managing miscarriages with medication or aspiration (65% and 14%, respectively) [13]. A recent study of family medicine physicians trained in abortion care found that only 37% of those who intended to provide abortions during training had done so five years later, with most providing at specialty abortion clinics [14]. This is not an issue unique to family medicine. In a study of obstetrician-gynecologists (OB/GYNs), about half (52%) of those who intended to provide abortions before residency were actually providing post-residency [15]. Stigma leading to institutional policies restricting abortion provision, as well as fear of repercussions from colleagues, were major reasons willing OB/GYNs were not providing abortion care [16]. While several studies have described these and other barriers OB/GYNs face in providing abortion after residency [15–18], the unique barriers among trained PCPs have not been systematically explored. Our study addresses this gap by describing barriers PCPs in New England face in integrating abortion into primary care practice to inform future interventions.

## 2. Material and methods

### 2.1. Eligibility criteria

We recruited PCPs who completed clinical training, self-identified as trained in medication or procedural abortion care, self-identified as desiring to provide abortion, and saw primary care patients in Rhode Island, Massachusetts, New Hampshire, Vermont, or Maine. We excluded Connecticut because it was the only New England state with no counties with greater than the national median distance of 15 miles to an abortion facility, indicating no regions of poor geographic access to abortion [19]. In order to characterize barriers and facilitators to providing abortion care among PCPs with varied experiences, we recruited a purposive sample to represent current abortion providers and those who are not currently providers but desire to provide (“would-be” abortion providers) in different primary care facility types, including community health centers, hospital-affiliated and/or academic-affiliated practices, and private practices. We also recruited physicians with geographic diversity from each state and a balance of rural, suburban, and urban practices, as categorized by participants.

### 2.2. Data collection

Interview recruitment spanned January 2019 to January 2020, via email outreach through reproductive health community partners, professional networks, and email listservs. Investigators screened prospective participants for eligibility until the sampling criteria were saturated.

A semi-structured interview guide explored clinicians' experiences with and barriers to incorporating abortion care into practice, based on the significant literature on drivers of abortion provision among OB/GYNs and the sparse literature on factors affecting PCP provision [12,17,20–23]. Interview guide domains included drivers of scope of practice, patient population and current practice setting, experience with training in reproductive health and abortion, and factors influencing ability to provide abortion care. Abortion providers detailed the steps they took in establishing an abortion care service. Those who were not providing abortions described all attempts and each barrier they faced. Interviewers probed on what they would need in order to become abortion providers. We also collected demographics—including race, ethnicity, gender, religion, level of religious participation, and years since completing medical school—at the end of the interview. The senior author [EJ], an interdisciplinary researcher with expertise in abortion research and qualitative methods, trained the primary author [CL], a medical doctor with prior qualitative methods training, to conduct the in-depth interviews. [CL] performed the interviews, which lasted approximately one hour, by phone, and audio-recorded calls with permission from participants. Participants received a \$50 gift certificate in appreciation of their time. A professional service transcribed recorded interviews verbatim. We reviewed transcripts for accuracy and removed identifying information. This study was approved by the Partners Institutional Review Board.

### 2.3. Analysis

We developed a short list of *a priori* codes, based on the interview guide, and informed by hypothesized domains derived from the published literature [12,17,20–23]. We hypothesized that social stigma, colleague opposition, and government regulations, including the mifepristone REMS, would affect trained clinicians' ability to provide abortion. We also hypothesized that a perceived

need for routine in-house ultrasound would be a barrier; though notably, the Society of Family Planning and American College of Obstetricians and Gynecologists clinical guidelines support an ultrasound-as-needed protocol for medication abortion [24].

Initially, [CL] and [EJ] coded 2 transcripts with the *a priori* codes, discussed emerging themes, and used a consensus method to agree upon additions and adjustments for a final coding schema. Each transcript was iteratively coded by 2 investigators ([CL, EJ, and/or SJ]). Using Atlas.ti software, investigators coded independently, used a consensus method to adjust coding as needed, and wrote narrative memos on each thematic area [25]. When investigators agreed that thematic saturation was reached and when we had achieved diversity on all sampling criteria, we stopped recruitment. Through iterative dialogue, using an inductive content analysis approach, we synthesized the themes and identified patterns in responses within each domain of inquiry.

### 3. Results

Out of 21 participants, most were mid-career PCPs with 6 to 20 years postmedical school practice years (Table 1). All were family medicine physicians except for one internist. Advanced practice clinicians including midwives, nurse practitioners, and physician’s assistants were included in recruitment outreach; however, the clinicians screened were not eligible for the study as they saw patients for specialty reproductive healthcare (more similar to an OB/GYN practice) rather than serving as PCPs. Participants worked in community health centers (48%), hospital- or academic-affiliated practices (38%), and private practices (14%). Most participants self-identified as non-Hispanic white (76%) and as a woman or female (86%). Most participants trained in abortion care during residency, but a few pursued fellowship training or on-the-job training after residency. Forty-three percent provided abortions in their primary care sites (some additionally provided in specialty abortion clinics), 10% provided abortions in specialty abortion clinics only, and 48% did not provide abortions.

Reported barriers fell into 2 categories: intraorganizational barriers and related external pressures and gaps. Intraorganizational barriers were driven by stigma and moral opposition to abortion and by interprofessional tension related to implementation of evidence-based protocols. External pressures and gaps included policy-level barriers such as the Hyde Amendment, which prevents the use of federal funds for most abortion care, and the mifepristone REMS, which prohibits routine mifepristone pharmacy dispensing; these policies, in turn, produced logistical hurdles within the clinical practice setting. Lastly, many interviewees were unaware of existing supports to help navigate these challenges.

#### 3.1. Stigma and moral opposition within the primary care practice

Regarding stigma and moral opposition, individual opposition among leadership, staff, and peers was a commonly cited barrier. PCPs reported fear of opposition or known anti-abortion sentiment that prevented establishment of services: “I started talking to my division chief, who was supportive but concerned, and she was like, ‘No. The CEO is anti-choice. Let’s wait for him to retire.’” (urban, not currently providing abortions, academic-affiliated) Another clinician was particularly concerned about their staff, “I’m always away from getting abortion in our practice as a regular treatment option because much of the support staff...I don’t even tell them I do abortions [outside of our primary care practice] because they’re conservative.” (rural, providing abortions in specialty clinic only, academic-affiliated). In line with these concerns, one physician reported backlash from staff after beginning to offer abortion care: “We tried one [clinical site], and there was sort of a revolt

by the staff there. There were some threats to go to the media and threats from protesters” (urban, current primary care abortion provider, academic-affiliated).

#### 3.2. Interprofessional tension

Multiple PCPs reported tensions with OB/GYN and radiology departments. PCPs reported challenges proposing evidence-based ultrasound-as-needed protocols and concern about clinical scope or “territory,” which delayed or prevented abortion service establishment:

There are underlying tensions between OB/GYN and family medicine in my community...And so if we do something wrong, it’s 10 times worse...When we have been working to set up [medication abortions] in the residency clinic, there’s been the sense that we have to do everything exactly the same way the OB/GYNs do it, including doing dating ultrasounds routinely...or

**Table 1**

Demographic characteristics of abortion-trained primary care providers in five New England states interviewed 2019–2020 (N = 21)

Characteristic	N	%
<i>Years since medical school graduation</i>		
0–5	4	19%
6–10	9	43%
11–20	7	33%
21+	1	5%
<i>Practice type</i>		
Community health center (Federally Qualified Health Center or similar)	10	48%
Hospital-affiliated and/or academic-affiliated	8	38%
Private practice	3	14%
<i>State</i>		
Maine	1	5%
Massachusetts	9	43%
New Hampshire	3	14%
Rhode Island	5	24%
Vermont	3	14%
<i>Setting</i>		
Urban	9	43%
Suburban	5	24%
Rural	7	33%
<i>Race/ethnicity</i>		
Asian or Asian American	1	5%
Black or African American	0	0%
Hispanic or Latino non-white	0	0%
Hispanic or Latino white	1	5%
White or Caucasian	17	81%
Multiracial	1	5%
Other	1	5%
<i>Gender</i>		
Female or woman	18	86%
Male or man	3	14%
<i>Religious affiliation</i>		
Atheist or none	15	71%
Buddhist	1	5%
Catholic	1	5%
Jewish	1	5%
Muslim	0	0%
Protestant	0	0%
Quaker	1	5%
Unitarian Universalist	2	10%
<i>Self-rated religious importance</i>		
Not at all important	13	62%
Not very important	4	19%
Fairly important	1	5%
Very important	2	10%
Most important	1	5%
<i>Religious service attendance</i>		
Never	14	67%
Once a month or less	6	29%
Twice a month or more	1	5%

Percentages may not add to 100% due to rounding.

they'll shut us down. (suburban, not currently providing abortions, academic-affiliated).

Further, one participant credited their success in providing abortions in primary care to their partnership with an OB/GYN who was expanding access to abortion care in their general OB/GYN department. Another clinician who chose to pursue ultrasound training as part of their abortion practice shared how they navigated the difficulty of doing ultrasounds, which was previously solely under the scope of the radiology department:

Getting ultrasound privileges [was a barrier]. And I don't think that this [barrier] is unique to me. I think that in bigger hospital systems where there's a radiology department, that can be kind of tricky. And the way it ended up working here is I just met one-on-one with the chief of the department, and I appealed to her politics. And we talked about timely access to abortion care in a patient-centered way, and that resonated with her, and so we were able to make this compromise. (urban, current primary care abortion provider, academic-affiliated).

### 3.3. Policy and related logistical barriers

Policy-level barriers cited included the mifepristone REMS, the Hyde Amendment, property lease restrictions for clinical practices, and concerns regarding malpractice insurance coverage. The REMS requirement for onsite stocking of mifepristone prior to December 2021 was an insurmountable barrier for both political and logistical reasons. One PCP shared how they felt about eliminating the mifepristone REMS policy:

Oh my God. [Having mifepristone available in retail pharmacies] would make things so much easier because, to be honest, ordering the medication is a big piece that makes you feel like you have to meet [colleagues] and get their blessings...I would have done medication abortion, to be honest, already if [ordering and stocking mifepristone] wasn't a requirement. (urban, not currently providing abortions, academic-affiliated).

One physician shared that talking about stocking mifepristone ended the conversation about providing abortions with their leadership: "I brought it up once or twice, and it was sort of like, "Oh, [mifepristone is] such a difficult thing to get because, pharmacy-wise, it's in a locked and keyed vault at certain academic environments." (rural, not currently providing abortions, Federally Qualified Health Center) Another clinician explained the challenge of getting approval to stock mifepristone: "Basically, you need somebody to sign off within the department to agree for the department to pay for [mifepristone] for you to stock it. It must have been months of [the paperwork] just literally bobbling around and nobody wanted to be the one whose name was affiliated with the approval for [medication abortion]." (suburban, current primary care abortion provider, hospital-affiliated).

Participants reported concerns regarding financial logistics, such as how to bill and code for abortions and how to ensure patients could afford care. Multiple clinicians at Federally Qualified Health Centers also spoke about the challenge of separating their funding streams in order to comply with the Hyde Amendment regulations. One PCP explained:

I guess the [community health center] doesn't have its finances very—doesn't have a good handle on its finances and so even if they wanted to and we made it a priority and I pushed for it, it would be very difficult, I think, to make sure we weren't putting federal funds towards abortion care. (urban, not currently providing abortions, Federally Qualified Health Center).

Demonstrating the significance of the barriers created by the Hyde Amendment, two PCPs that provided aspiration procedures for first trimester miscarriage management at their Federally Qualified Health Center primary care sites could not provide first trimester abortions in primary care even though the procedure is essentially identical. Another physician shared an example of a property lease restriction that only allowed medication abortions, which the administration interpreted as occurring off-site:

The building has in its lease that we cannot perform abortions on-site. And so because of that, [the administration] said, 'You can do it for a miscarriage. You can do medication abortion, totally fine. But you can't do [manual vacuum aspirations] for abortion care inside the building.' (urban, current primary care abortion provider, academic-affiliated).

### 3.4. Lack of knowledge of external supports

PCPs also discussed how a lack of a clinician support network or role models left them unsure how to navigate these logistics. Without peer advisors, participants described feeling overwhelmed by the logistics of establishing a new service. PCPs not providing abortions were largely unfamiliar with existing resources, such as example protocols or the Toolkit for Integrating Abortion into Primary Care from the Reproductive Health Access Project (RHAP) [26].

## 4. Discussion

This study explores why some willing, trained PCPs are not able to provide abortion care in New England primary care settings. By recruiting PCPs in a variety of rural, suburban, and urban practice settings at different stages in their postresidency career, we included varied voices and experiences to better understand the landscape of barriers to providing abortions in primary care.

Our findings echo several prior studies among OB/GYNs [16,17,23]. Like OB/GYNs who report significant interpersonal barriers to providing abortion care in generalist practice, [23] PCPs desiring to provide abortion care face interpersonal stigma and moral opposition from their peers and struggle to develop a clinician support network. Further, in a 2010 study of OB/GYNs, significant barriers included explicit and implied institutional policies in addition to interpersonal stigma and desire to maintain professional collegiality [16]. Another study found that among OB/GYNs not providing medication abortions, 28% said they would if they could write a prescription for mifepristone, [23] a finding consistent with a prior study of PCPs and with our results [27]. Both OB/GYNs and PCPs seeking to provide abortion would likely benefit from interventions focused on finding mentors and increasing self-efficacy, such as a learning collaborative model [28].

However, PCPs also face unique barriers to providing abortion. For example, our participants consistently reported interprofessional tensions with both radiology and OB/GYN. Conflict with radiology is not prominent in prior literature on barriers to abortion provision among OB/GYNs, and recent national studies describing barriers and facilitators of abortion in primary care [29,30] do not name conflicts with radiology or OB/GYN as major barriers. Many of our participants discussed a perceived need for ultrasound, difficulty obtaining ultrasound machines, and difficulty obtaining privileges to perform ultrasounds as significant barriers, often related to these interspecialty frictions. Our findings highlight a need for more cross-specialty partnerships and underscore the importance of education regarding the evidence-based ultrasound-as-needed protocol to advance abortion care access in primary care [24].

Across diverse practice types, a lack of organizational support took many forms: sometimes as direct interpersonal opposition

from leadership and staff, other times as opposition enacted in the form of bureaucratic hurdles like requirements for ultrasound and surgical backup protocols, excessive obstacles to medication and equipment stocking, and extensive clinical privileging requirements. Moreover, barriers across multiple levels were interrelated. For example, the Hyde Amendment forbidding use of federal funds to reimburse most abortion care is a policy-level barrier. As a result of this policy, Federally Qualified Health Centers offering abortion must adhere to strict regulations about separating federal funds to ensure they are not used for abortion care, except in cases of rape, incest, or threat to the pregnant person's life. The process of separating funds, in turn, constitutes a logistical hurdle that providers must overcome. Similarly, until December 2021 the mifepristone REMS policy required mifepristone be dispensed directly to a patient in a clinical setting, and has since that time still required dispensing by a specially certified pharmacy, rather than prescribed for pickup at a retail pharmacy. In both cases, the logistical barriers created by these policies require the involvement and cooperation from multiple, additional stakeholders for successful implementation of abortion services, creating more opportunities for interpersonal level barriers around abortion stigma and moral opposition to arise. Similar to our findings, a recent study of family medicine physicians found that the REMS “transform[ed] the decision to provide mifepristone from being one between a physician and patient, to involving multiple levels of administration” [31].

Post-Roe, it is predicted that states where abortion is legal will experience a large influx of patients from surrounding states, likely with more advanced gestational ages. We hypothesize these traveling patients may have an increased demand for procedural abortions over medication abortions due to gestational age and the need for quick completion of the termination process. If specialty abortion clinics see high volumes of patients coming from numerous states, wait times for appointments may spike. This happened previously in the context of increasing abortion restrictions, including since Texas began enforcing a 6-week abortion ban in September 2021 [32,33]. In this environment of constrained access, it is even more important that PCPs in states with legal abortion offer their patients abortion care, ideally with both medication and procedural options, rather than referring local patients to overburdened specialty clinics.

Overall, our study does suggest that medication abortion would likely be easier to implement for most PCPs compared to procedural abortion. PCPs regularly prescribe medications with far more complicated regimens and with more significant side effects than mifepristone and misoprostol. If the REMS were eliminated, mifepristone could be prescribed to retail pharmacies. For PCPs comfortable with options counseling, training to provide medication abortion could realistically be provided through a brief article or video, in contrast with the hands-on training required to provide procedural abortions [34]. Further, if an evidence-based ultrasound-as-needed protocol is used, the perceived need to purchase ultrasound machines is removed. By breaking down the barriers described in our study, a PCP could hypothetically use existing clinical protocols and begin offering abortion care within days.

This study has limitations. Though we prioritized recruitment of rural clinicians in New Hampshire, Vermont, and Maine, the sample overrepresented Massachusetts and Rhode Island and nearly half of participants worked in urban settings. However, themes gathered from urban, suburban, and rural interviewees did not differ dramatically. Participants were less religious than physicians nationally (71% atheist vs 11.6% atheist nationally) [35]. There were no Black participants and interviewees were mostly white. This homogeneity impaired our ability to describe any potential role that racialized identities play in abortion training, interprofessional tension, and other factors affecting care provision. Given the particularities of the regional political landscape, state policies, and

the culture of primary and specialty care in the Northeast, the results also may not be generalizable to regions outside of New England. Similar investigations are warranted to describe barriers in different regions where abortion is likely to remain legal, such as the West Coast and in certain Midwestern and Southwestern states.

Increased abortion provision in primary care is one of many necessary responses to the human rights crisis produced by the *Dobbs* decision. In the rapidly shifting policy landscape, where federal regulations such as the REMS may be modified and states may increasingly widen scope of practice for more clinicians to provide abortion, awareness of the barriers that PCPs face will be crucial in supporting them to help close the access gap.

## References

- [1] Jones RK, Jerman J. Population group abortion rates and lifetime incidence of abortion: United States, 2008–2014. *AJPH* 2017;107:1904–9. doi:10.2105/AJPH.2017.304042.
- [2] Supreme Court of the United States *Dobbs v. Jackson Women's Health Organization*; 2022. [https://www.supremecourt.gov/opinions/21pdf/19-1392\\_6j37.pdf](https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf). [accessed 4 Aug 2022].
- [3] Nash E, Cross L. Guttmacher Institute 26 states are certain or likely to ban abortion without Roe: here's which ones and why; 2021. <https://www.guttmacher.org/article/2021/10/26-states-are-certain-or-likely-ban-abortion-without-roe-heres-which-ones-and-why>. [accessed 4 Aug 2022].
- [4] Nash E. Guttmacher Institute State abortion policy landscape: from hostile to supportive; 2019. <https://www.guttmacher.org/article/2019/08/state-abortion-policy-landscape-hostile-supportive>. [accessed 4 Aug 2022].
- [5] Jones RK, Witwer E, Jerman J. Abortion incidence and service availability in the United States, 2017. Guttmacher Institute; 2019.
- [6] USDHHS State-level projections of supply and demand for primary care practitioners: 2013–2025. US Department of Health and Human Services; 2016. <https://bhwhrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-state-projections2013-2025.pdf>. [accessed 5 Nov 2020].
- [7] Beaman J, Schillinger D. Responding to evolving abortion regulations - the critical role of primary care. *NEJM* 2019;380:e30. doi:10.1056/NEJMp1903572.
- [8] Godfrey EM, Rubin SE, Smith EJ, Khare MM, Gold M. Women's preference for receiving abortion in primary care settings. *J Womens Health* 2010;19:547–53. doi:10.1089/jwh.2009.1454.
- [9] Logsdon MB, Handler A, Godfrey EM. Women's preferences for the location of abortion services: a pilot study in two Chicago clinics. *Maternal and Child Health J* 2012;16:212–16. doi:10.1007/s10995-010-0722-4.
- [10] Prine LW, Lesniewski R. Medication abortion and family physicians' scope of practice. *J Am Board Fam Pract* 2005;18:304–6. doi:10.3122/jabfm.18.4.304.
- [11] National Academies of Sciences E, Medicine CoRHS The safety and quality of abortion care in the United States; 2018. doi:10.17226/24950.
- [12] Janiak E, Holt K, Bartz D, Gottlieb B, Kajeepeta S, Langer A. Abortion training and provision among practicing US primary care physicians: results from a national survey. *North Am Forum Family Plann* 2015.
- [13] Herbitter C, Bennett A, Schubert FD, Bennett IM, Gold M. Management of early pregnancy failure and induced abortion by family medicine educators. *J Am Board Fam Med* 2013;26:751–8. doi:10.3122/jabfm.2013.06.120248.
- [14] Srinivasulu S, Maldonado L, Prine L, Rubin SE. Intention to provide abortion upon completing family medicine residency and subsequent abortion provision: a 5-year follow-up survey. *Contraception* 2019;100:188–92. doi:10.1016/j.contraception.2019.05.011.
- [15] Steinauer J, Landy U, Filippone H, Laube D, Darney PD, Jackson RA. Predictors of abortion provision among practicing obstetrician-gynecologists: a national survey. *Am J Obstet Gynecol* 2008;198:39.e1–39.e6. doi:10.1016/j.ajog.2007.06.002.
- [16] Freedman L, Landy U, Darney P, Steinauer J. Obstacles to the integration of abortion into obstetrics and gynecology practice. *Perspect Sexual Reprod Health* 2010;42:146–51. doi:10.1363/4214610.
- [17] Harris LH, Cooper A, Rasinski KA, Curlin FA, Lyerly AD. Obstetrician-gynecologists' objections to and willingness to help patients obtain an abortion. *Obstet Gynecol* 2011;118:905–12. doi:10.1097/AOG.0b013e31822f12b7.
- [18] Allen RH, Raker C, Steinauer J, Eastwood KL, Kacmar JE, Boardman LA. Future abortion provision among US graduating obstetrics and gynecology residents, 2004. *Contraception* 2010;81:531–6. doi:10.1016/j.contraception.2010.01.001.
- [19] Jones RK, Jerman J. How far did US women travel for abortion services in 2008? *J Womens Health* 2013;22:706–13. doi:10.1089/jwh.2013.4283.
- [20] Holt K, Janiak E, McCormick MC, et al. Pregnancy options counseling and abortion referrals among US primary care physicians: results from a national survey. *Fam Med* 2017;49:527–36.
- [21] Romero D, Maldonado L, Fuentes L, Prine L. Association of reproductive health training on intention to provide services after residency: the family physician resident survey. *Fam Med* 2015;47:22–30.
- [22] Greenberg M, Herbitter C, Gawinski BA, Fletcher J, Gold M. Barriers and enablers to becoming abortion providers: the reproductive health program. *Fam Med* 2012;44:493–500.

- [23] Grossman D, Grindlay K, Altshuler AL, Schulkin J. Induced abortion provision among a national sample of obstetrician-gynecologists. *Obstetr Gynecol* 2019;133:477–83. doi:10.1097/AOG.0000000000003110.
- [24] Creinin M, Grossman DA. Medication abortion up to 70 days of gestation. *Contraception* 2020;102:225–36. doi:10.1016/j.contraception.2020.08.004.
- [25] Miles M HA. *Qualitative data analysis: an expanded sourcebook*. 2nd Ed. Newbury Park, CA: Sage Publications; 1994.
- [26] Reproductive Health Access Project Toolkit for integrating abortion into primary care; 2019. <https://www.reproductiveaccess.org/resource/toolkit-integrating-abortion-primary-care/>.
- [27] Srinivasalu S, Yavari R, Brubaker L, Riker L, Prine L, Rubine SE. US clinicians' perspectives on how mifepristone regulations affect access to medication abortion and early pregnancy loss care in primary care. *Contraception* 2021;104:92–7. doi:10.1016/j.contraception.2021.04.017.
- [28] Calloway D, Stulberg DB, Janiak E. Mifepristone restrictions and primary care: breaking the cycle of stigma through a learning collaborative model in the United States. *Contraception* 2021;104:24–8. doi:10.1016/j.contraception.2021.04.002.
- [29] Razon N, Wulf S, Perez C, McNeil S, Maldonado L, Fields AB, et al. Family physicians' barriers and facilitators in incorporating medication abortion. *J Am Board Fam Med* 2022;35:579–87. doi:10.3122/jabfm.2022.03.210266.
- [30] Summit AK, Lague I, Dettmann M, Gold M. Barriers to and enablers of abortion provision for family physicians trained in abortion during residency. *Perspect Sexual Reprod Health* 2020;52:151–9. doi:10.1363/psrh.12154.
- [31] Razon N, Wulf S, Perez C, McNeil S, Maldonado L, Fields AB, et al. Exploring the impact of mifepristone's risk evaluation and mitigation strategy (REMS) on the integration of medication abortion into US family medicine primary care clinics. *Contraception* 2022;109:19–24. doi:10.1016/j.contraception.2022.01.017.
- [32] White K, Vizcarra E, Palomares L, Dane'el A, Beasley A, Ogburn T, et al. Initial impacts of Texas' Senate Bill 8 on abortions in Texas and at out-of-state facilities. Texas Policy Eval Project 2021. <https://sites.utexas.edu/txpep/files/2021/10/initial-impacts-SB8-TxPEP-brief.pdf>. [accessed 4 Aug 2022].
- [33] White K, Baum SE, Hopkins K, Potter JE, Grossman D. Change in second-trimester abortion after implementation of a restrictive state law. *Obstetr Gynecol* 2022;133:771–9. doi:10.1097/AOG.0000000000003183.
- [34] Schwarz EB, Sobota M, Goodman S. Medication Abortion in Primary Care. UCSF CME 2022. <https://abortionpillcme.teachtraining.org/>. [accessed 4 Aug].
- [35] Robinson KA, Cheng MR, Hansen PD, Gray RJ. Religious and spiritual beliefs of physicians. *J Religion Health* 2017;56:205–25. doi:10.1007/s10943-016-0233-8.