

Views and Practices of Women's Health Care Providers on Medical Abortion: An Update on Mifepristone

On September 28, 2000, the U.S. Food and Drug Administration (FDA) approved mifepristone (also known as RU486) for use as a non-surgical method of early abortion. Many abortion rights advocates had hoped that the arrival of mifepristone would help address problems of access to abortion by increasing the number of doctors who offer abortions as part of their practices. Opponents of abortion raised concerns that the drug would increase the number of abortions.

In a national survey conducted by the Kaiser Family Foundation prior to FDA approval, many physicians –including a significant percentage of gynecologists and family practice physicians who did not or had never performed surgical abortions – expressed interest in providing a non-surgical option.

Following FDA approval in September 2000, the Foundation surveyed women's health care providers between May and August 2001. Findings show that a relatively small proportion – 6 percent of gynecologists and 1 percent of general practice physicians – had used the drug to provide early medical abortions in the nine months since distribution began. An additional 16 percent of gynecologists and 7 percent of general practice physicians indicated that they were likely to start offering it within the next year. Gynecologists who currently or recently provided surgical abortions are most likely to report that they now offer medical abortions or plan to do so soon.

Approximately four in ten physicians say they do not provide mifepristone because they are personally opposed to medical abortion. Despite these views, one-third to half of these doctors say they will still make referrals for patients seeking a medical abortion.

Top reasons cited by those who do not provide mifepristone but are not personally opposed to medical abortion include a perceived lack of patient demand, concerns about protests or violence, the political controversy surrounding abortion, and personal lack of interest in providing these services.

Following is a detailed summary of findings from this most recent survey of 595 obstetricians and gynecologists (referred to as "gynecologists") and 195 internists, family practitioners, and general practitioners (referred to as "general practice physicians") conducted in the summer and fall of 2001.

Mifepristone in the U.S.

FDA approval of mifepristone came more than two decades after a French pharmaceutical firm announced it had developed the drug for use in early abortions. Since 1988, when France became the first country to approve mifepristone, millions of women in some 20 countries – including more than 600,000 in Europe alone – have obtained early abortions using mifepristone.^{1,2}

Between 1994 and 1995, more than 2,000 U.S. women participated in large-scale clinical trials conducted by the Population Council, the non-profit research organization that holds the U.S. patent.³ The FDA began considering an application for mifepristone's approval in 1996, issuing a letter later that same year acknowledging that the drug is safe and effective.

Mifepristone is marketed in the U.S. as Mifeprex. Taken in conjunction with a second drug (misoprostol, also known as Cytotec), mifepristone is FDA approved to terminate a pregnancy during the first 49 days of pregnancy (seven weeks) – and studies show that this combination can be used effectively up to 63 days (nine weeks).²

Mifepristone is not available through commercial pharmacies. The drug's distributor – Danco Laboratories – must provide it directly to physicians deemed "eligible" to provide medical abortions. Under the terms of FDA approval, physicians must meet certain criteria: They must be able to accurately determine the duration of pregnancy, detect an ectopic pregnancy, and arrange for surgical back up in cases of severe bleeding or incomplete abortion. They are not required to have received specific training in either surgical or medical abortion techniques.

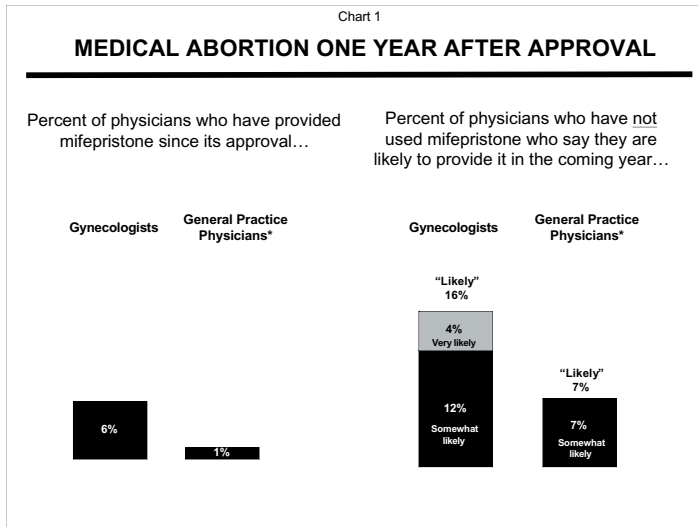
The FDA-approved mifepristone regimen involves three visits to a health care provider (the first for mifepristone; a second 48 hours later for the misoprostol; and a third 10-15 days later to confirm the abortion was completed). Researchers are finding that alternative protocols – using a smaller mifepristone dose and eliminating the second visit by allowing home use of misoprostol – are equal to or more effective than the FDA-approved regimen. Some physicians are using these "evidence-based" regimens, reflecting the common practice of using an approved drug in a manner supported by published data but not included in the product's labeling.²

Summary of Findings

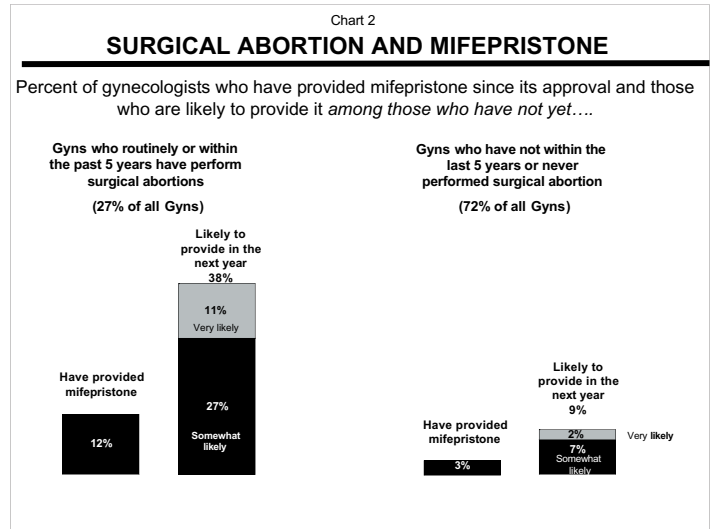
The vast majority of abortions are performed in facilities that specialize in providing these services (See Surgical Abortion Practices below). One year after FDA approval of mifepristone, half of the members of the National Abortion Federation – the professional association of abortion providers – reported offering medical abortions, as did about two-thirds of the Planned Parenthood Federation of America affiliates that provide abortion services.⁴ The Kaiser Family Foundation survey reflects the views and practices of individual physicians, in an effort to better understand whether approval of mifepristone is expanding the pool of abortion providers.

Medical Abortion Practices

Within the first year after FDA approval, six percent of gynecologists and one percent of general practice physicians provided medical abortions using mifepristone. There are also indications that the number of doctors who offer medical abortions could increase in the coming year, with an additional one in six gynecologists (16%) and 7 percent of general practice physicians saying they are likely to start to do so (See Chart 1).

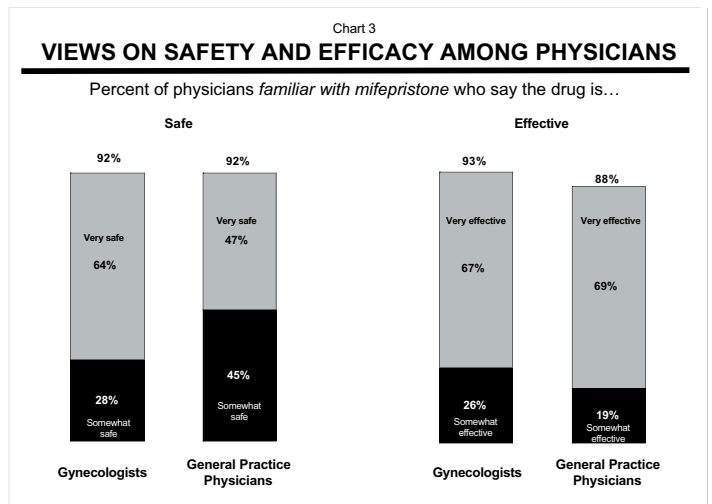


Physicians most likely to offer mifepristone are gynecologists who have performed surgical abortions within the last 5 years. Gynecologists who already offer surgical abortion (27% of all gynecologists) are four times more likely to have provided mifepristone since its approval—12 percent vs. 3 percent of those who do not offer surgical abortion. And they are also more likely to say that they will provide it in the next year if they do not do so already (38 percent vs. 9 percent, respectively)(See Chart 2).



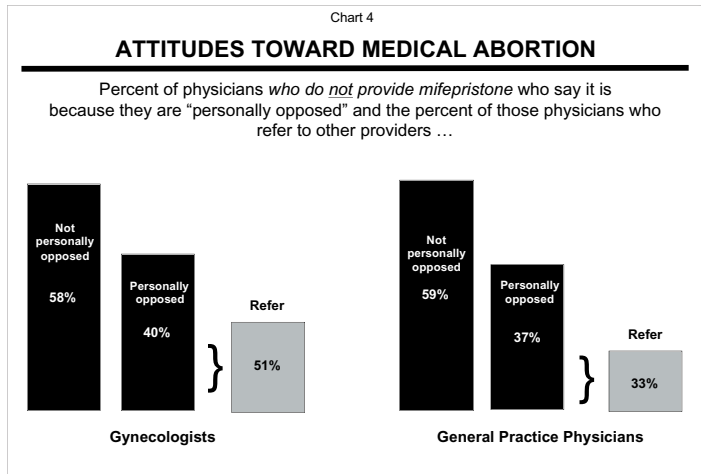
Familiarity, Safety, and Efficacy of Mifepristone

More than eight in 10 (82%) gynecologists and six in 10 (61%) general practice physicians report being familiar with the medical abortion regimen involving mifepristone. And among those who are familiar with mifepristone, safety and efficacy are rated high: 92 percent of gynecologists and general practice physicians say they consider it “very” or “somewhat” safe when used under a doctor’s care; 93 percent of gynecologists and 88 percent of general practice physicians say it is “very” or “somewhat” effective under those same conditions (See Chart 3).



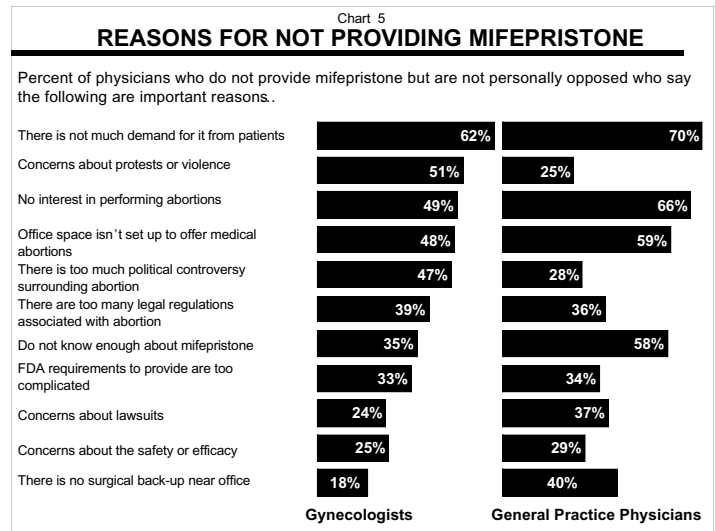
Factors Influencing Decisions Not to Offer Mifepristone

Among those physicians who have not provided mifepristone since its approval, four in ten (40% of gynecologists and 37% of general practice physicians) say it is because they are personally opposed to elective medical abortions. However, even among those not providing mifepristone because they are personally opposed, 51 percent of gynecologists and 33 percent of general practice physicians say they will make referrals for women seeking elective medical abortions (See Chart 4).



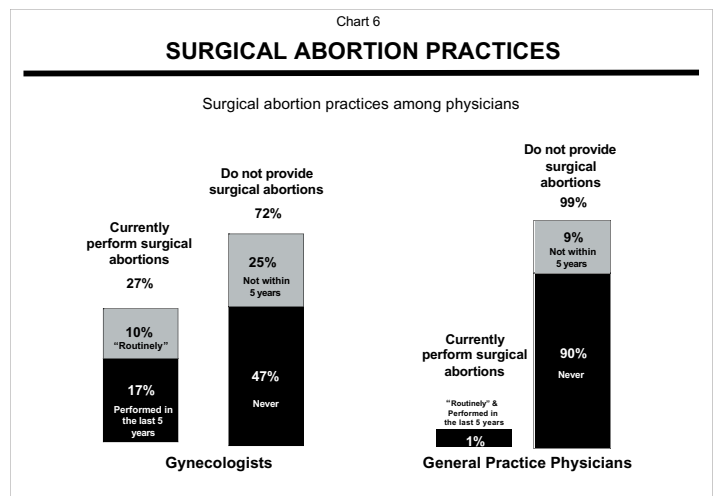
Additionally, 39% of gynecologists and 21 percent of general practice physicians who have not provided mifepristone say their practice has a policy against medical abortion. Physicians also face barriers to providing medical abortions at the hospitals at which they practice—40 percent of gynecologists and 30 percent of general practice physicians say that at least one of the hospitals at which they practice has a policy against medical abortion.

Among physicians who are not personally opposed yet do not now offer mifepristone, perceived lack of patient demand is cited by the majority of both gynecologists and general practice physicians as an important reason why not (62% and 70%, respectively). Among gynecologists, concerns about protests or violence (51%), no interest in performing abortions (49%), office space concerns (48%), and the political controversy surrounding abortion (47%) are also important issues. No interest in performing abortion (66%), office space concerns (59%), and lack of knowledge about mifepristone (58%) are cited by about six in 10 general practice physicians (See Chart 5).



Surgical Abortion Practices

Approximately one in four gynecologists (27%) and one percent of general practice physicians routinely offer or have performed surgical abortions in the past five years (See Chart 6). Half (53%) of gynecologists and one in three general practice physicians (33%) who have not performed a surgical abortion in the past five years or ever say that it is because they are personally opposed to elective surgical abortions.

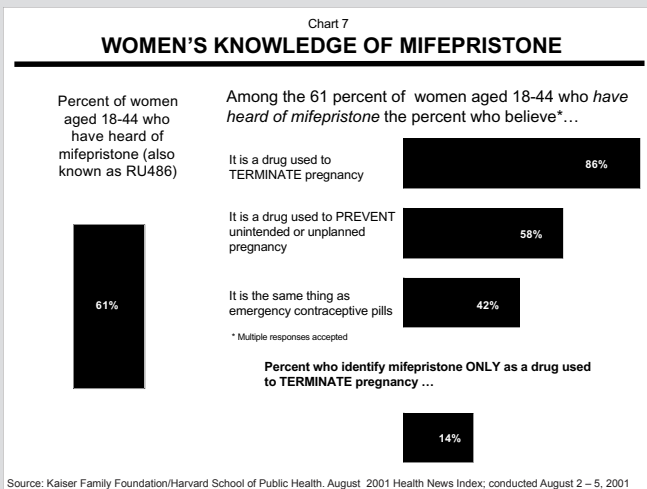


In 1996, the most recent year for which data are available, 70 percent of all abortions in the U.S. took place in facilities that specialize in these procedures – meaning that at least half of their patient visits were for abortion services. Twenty-one percent (21%) took place in other kinds of clinics; seven percent in hospitals; three percent in private physicians' offices.⁵

Awareness of Mifepristone Among Women of Reproductive Age

In a national survey conducted by the Kaiser Family Foundation in 2001, six out of 10 women 18-44 (61%) have heard of mifepristone or RU486. This represents an increase since 1997, when 40 percent said they had heard of the drug.

However, misinformation still persists, with many confusing it with emergency contraceptive (EC) pills – a back-up method of birth control that is used to prevent pregnancy after unprotected sex or in the event of a contraceptive failure. While 86 percent of those who had heard of mifepristone correctly identify it as a drug used primarily to terminate pregnancy, many of these same women also believe that it is the same thing as emergency contraceptive pills (42%); only 14 percent identify mifepristone only as a non-surgical abortion option. (See Chart 7).



When asked about mifepristone's safety and efficacy, almost 4 in 10 of those who have heard of the drug say they do not know enough to answer, while 49 percent say they think it is safe and 56 percent say they think it is effective.

Methodology

The Kaiser Family Foundation's 2001 National Survey of Women's Health Care Providers on Reproductive Health is a national random-sample survey of 790 physicians, including 595 obstetrician and gynecologists and 195 family practice physicians, internists, and general practitioners. The questionnaire was designed by staff at the Kaiser Family Foundation and Princeton Survey Research Associates (PSRA) and analyzed by staff at the Foundation. Interviews were conducted by telephone by PSRA between May 15-August 28, 2001. The sample was drawn from the American Medical Association's Masterfile. The final response rate was 59 percent. The data have been weighted by age, gender, and region to be representative of national samples of gynecologists and general practice physicians and to account in part for nonresponse. The margin of error is plus or minus 4 percent for gynecologists and plus or minus 7 percent for general practice physicians and may be larger for certain subsets presented in this analysis.

The public awareness data was collected as part of the Foundation's August 2001 Health News Index, an ongoing national survey conducted in conjunction with the Harvard School of Public Health to track awareness and knowledge of health issues in the news. The questions were designed and analyzed by the Foundation. Fieldwork was conducted by telephone by PSRA with 1005 adults aged 18 and older between August 2-5, 2001. The margin of error is plus or minus 3 percent overall, and plus or minus 7 percent for women aged 18-44.

References

- 1 Creinin M, Medical abortion regimens: Historical context and overview, American Journal of Obstetrics and Gynecology Supplement 2000, 183:S3-S9; U.S. Department of Health and Human Services, Press Release: FDA Approves Mifepristone for the Termination of Early Pregnancy, September 28, 2000.
- 2 Stewart FH et al., Early Medical Abortion: Issues for Practice. UCSF Center for Reproductive Health Research & Policy: San Francisco, CA, 2001.
- 3 Spitz I et al., Early pregnancy termination with mifepristone and misoprostol in the United States, New England Journal of Medicine 1998, 338:1241-47.
- 4 National Abortion Federation, Press Release: One Year After FDA Approval of Mifepristone, Health Care Providers Are Offering and Patients Are Choosing Safe Early Abortion Option, September 24, 2001; Planned Parenthood Federation of America, Press Release: Majority of Health Centers Provider Abortion Services Offer New Early Option, September 24, 2001.
- 5 Henshaw SK, Abortion incidence and services in the United States, 1995-1996, Family Planning Perspectives, 1998, 30(6): 263-70.

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