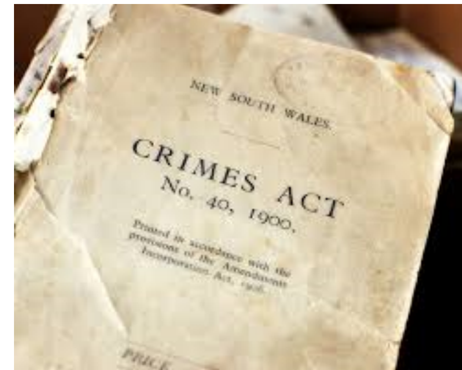
Enhancing medical termination of pregnancy (MTOP) in general practice in Australia: insights from a qualitative study of GPs in NSW



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Medical abortion in Australia

- Mifepristone & misoprostal available since late 80s (WHO Essential Medicines list)
- Severely restricted in Australia pre-2012
- 2013 PBS-listed; 2015 MS-2 Step licensed up to 63 days gestation
- GPs able to provide MTOP with accredited training
- Comprehensive Australian safety data available *(Goldstone et al)*
- Rise in MTOP vs STOP from 24.7% in 2012 to 39.7% in 2017 *(MSA data)*

➢ **Affordable, acceptable, accessible abortions a possibility……**

Access to abortion in NSW.....

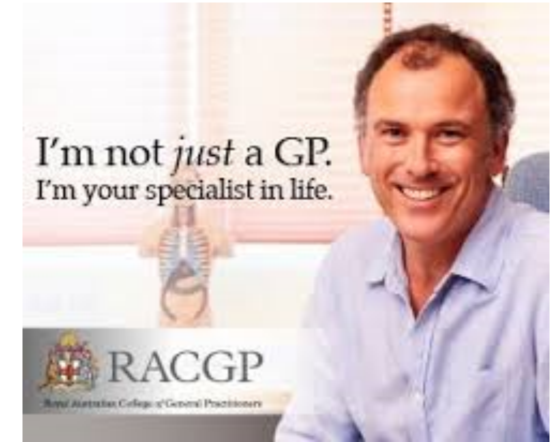
•Vast majority NSW abortions occur in private clinics; median MTOP cost $560; public hospital abortion provision rare to extremely rare

➤ **GPs: ideally positioned to provide MTOP........**

➤ Highly trusted by the community

➤ Potential to provide accessible, low cost, holistic services including options counselling, STI screening, contraception, continuity of care

GPs: uptake of MTOP training and service provision lower than expected?



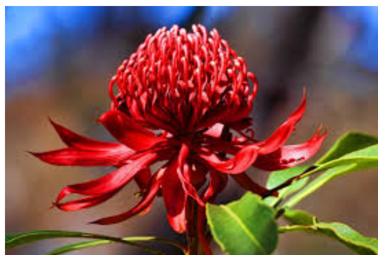
•1.5% of 81,478 registered medical practitioners in Australia certified to prescribe; 308 of 26,112 in NSW *(2014/5 AIHW; MS Health)*

•*2018 data (MS Health) 212 GP prescribers in NSW (462 overall)*

•**No publically-available information** on GP providers…

Insights from a qualitative study of GPs in NSW:

aimed to explore provision and referral by GPs in NSW among non-providers, providers and those who might provide in future



Towards comprehensive early abortion service delivery in high income countries: insights for improving universal access to abortion in Australia

Dawson A., Bateson D., Estoesta J., Sullivan E.

BMC Health Services Research 2016 16:612

Methodology: a descriptive-interpretive qualitative study

- **Purposeful sampling for diversity:** gender, practice (sole practitioner, 2-5 GPs, 5+ GPs) & community (geographical area, LHD)
- Emails & letters: 72 GPs in 8 locations
- **32 GPs (1 GP surgeon)**; 9 male; 16 metro, 13 inner regional, 1 outer regional, 1 remote/very remote
- **8 providers (experience 4m – 2 years); 24 non-providers**
- 1x focus group (n=4); 28 semi-structured interviews recorded and transcribed verbatim; imported into NVivo10; emergent themes identified when saturation reached
- **Multi-professional perspectives**

Three main themes emerged:

- Scope of practice
- MTOP demand, clinical care and referral
- Workforce needs

Scope of practice: someone else's work

- Low knowledge and awareness of GP provision
- More than one GP unsure if ECP was an abortifacient; some uncertainty of abortion legality
- Many considered it beyond their scope of practice & a service provided by others in private clinics
- *I don't think I'm going to chase that expertise and do it myself ever. I'd rather someone else handle that* **GP non-provider, metro**
- *I need my employer to accept that its within the scope of practice* **GP non-provider, inner regional**

Scope of practice: all too hard

- Perceived as complicated, difficult & ***all too hard***
- Some non-providers overwhelmed by current workload & worried about being ***inundated;*** concerns about multiple patient visits, longer counselling times, time spent consulting local pharmacists and establishing referral pathways, possibility of after hours care
- GP surgeon STOP provider at rural public hospital decided against offering it due to perceived difficulties ensuring follow up
- ***Its not just a matter of giving a pill*** **GP provider inner regional**

Scope of practice: stigma of becoming ‘the abortion doctor’

- Worries about impact on practice reputation
- Some viewed it as unpleasant; some had personal beliefs preventing provision
- *Even some of my colleagues…when they found out I’m doing these things, they have viewed me differently which is a bit depressing* **GP provider metro**
- *They (friends) responded more negatively than I thought they would* **GP provider metro**
- One noted stigma was not an issue in a specialised setting **GP provider metro;** another that practicalities were more significant than stigma **GP non-provider metro**

Abortion information and referral

- All stated they referred women even if personally opposed
- Most patients **did not ask** about MTOP; perception among providers that women weren't always given a choice
- Lack of public referral noted; only in extenuating circumstances with 'clear justification'
- One GP could informally refer 1 person ***every 2-years based on goodwill*** **GP non-provider inner regional**
- ***eventually I got one from one of the obstetrician's here.. he basically sort of said oh for God's sake….. I'll do it but I'm not doing it again*** **GP non-provider outer regional**
- ***…a matter of exhausting all other avenues of loans and brokerage…to get a private clinic to assist with bulkbilling for low income patients*** **GP non-provider metro**

MTOP: establishing clinical pathways

(medications, anti-D, ultrasound, complications)

- *We had to hunt it (medications) down and the chemist didn't have it in stock and it was a little bit of thing…if they only need it once in a blue moon* **GP provider rural**
- A GP who also worked in a private clinic couldn't find accredited pharmacists to set up in general practice *just ended up being too hard* **GP provider metro**
- *Asking them for a favour (performing an US)…which they've already stipulated that they don't actually want to do it* **GP provider regional**
- Good contacts and a *friendly (public hospital) gynae* seen as essential for clinical backup
- One GP stopped services after local gynae refused management of retained products **GP provider metro**

MTOP: follow-up demands

- Some providers worried about overload with complex patients and planned to limit numbers; some were more comfortable providing to regular patients who lived locally
- *We have a huge drop out rate, a huge number of people that don't come back… phone numbers not correct…. I find that more stressful than anything else, not knowing* **GP provider metro**
- *My main problems is because I provide it very cheaply or bulk-billed….despite my best efforts I am still having great problems getting people to come back* **GP provider metro**

MTOP: supply and demand

- Most providers were utilising their skills but demand varied; GPs who also worked in private clinics highlighted demand differences
- Some unsure if their service was needed; ***I've actually only had 2 requests…they may be self-referring*** **GP provider metro**
- GPs themselves unaware of other local providers; ***I don't know if I'm the only doctor in town who's on the register…so I don't know what the demand is here ..whether I'm one of ten or the only one…I have no way of knowing*** **GP provider inner regional**
- Non-providers also unsure of local GP services ***there's rumours about a prescriber for medical in town but I don't know if its true or not*** **GP non-provider inner regional**

MTOP: when things go right..

It was all very nice – as though it was part of a holistic care package – I was able to manage the complication for her with a good understanding of her family circumstances…I think it worked well for her

GP provider metro

Workforce needs: isolation and support

- Providers mainly women in 30-40s with children committed to comprehensive SRH care; often part-time work with concerns about continuity of care ***…colleagues willing to provide backup for all my patients except for abortion*** **GP (male) provider**
- 25% providers motivated to assist rural and low income women
- BUT often felt isolated and had difficulty in building expertise
- ***I'm kind of a young doctor doing it all by myself*** **GP provider regional**
- ***I'm not ready at this point. I'm a young doctor so I want more confidence but who is going to mentor me?*** **GP non-provider regional**

Workforce needs: training gaps

- Lack of awareness of training; non-providers often had **poor understanding** of processes involved
- Certification course generally positively received; **gaps in translation** to practice, peer support and professional development noted
- Low numbers of GP MTOPs **limits opportunity** to accumulate experience
- **Sensitivity training** of reception staff viewed as important

Insights for future planning and service delivery

- **Scope for increased knowledge and awareness** of MTOP at community and professional levels
- **Increased awareness** of GP training; medical school exposure; professional body engagement
- **Build communities of practice** to prevent isolation & foster best practice through **publically-funded** hub and spoke models

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
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Insights for future planning and service delivery

- **GPs can and do** play an important role in abortion service delivery but often **'against the odds'**
- **Whole of health service** support essential; **government cannot** abrogate responsibility for public sector provision and support
- **Flexible service delivery models** needed at policy and practice-based levels
- **Leadership and coordination** across the health sector to facilitate integrated abortion care particularly for rural and low-income women

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Medical termination of pregnancy in general practice in Australia: a descriptive-interpretative qualitative study. Dawson A et al. Reproductive Health 2017; 14:39