



# Decision-making concerning unwanted pregnancy in general practice

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Received August 29 2013; revised March 3 2014; Accepted May 19 2014.

## Abstract

**Background.** In the Netherlands, termination of pregnancy is legal under well-defined conditions. Before undergoing the procedure, women have to observe a 5-day 'reflection period'. The official start of this period has to be established by a medical doctor, most frequently the GP.

**Objective.** To provide insight into the elements of counselling by GPs regarding unwanted pregnancies and the relationship between GP-reported elements of counselling and whether women change their minds concerning their wish for pregnancy termination or *vice versa*.

**Methods.** Data were collected via the registration system of the NIVEL Primary Care Database Sentinel Practices from 2004 to 2010. Standardized registration forms were used to collect data on unwanted pregnancy consultations. The data were analysed by chi-square analyses and logistic regression methods.

**Results.** Most women who consulted their GPs for unwanted pregnancy opted for an abortion and did not change their minds. Approximately one in six patients were undecided. Of the women who had made up their minds, 8% altered their decision after consultation with their GP. Women with a higher gestational age and those who discussed alternatives with their GP were more likely to change their minds after consulting their GP. Women who were referred to an abortion clinic were less likely to change their minds.

**Conclusion.** In the case of unwanted pregnancy, discussion of all options in a protocolized way by the GP may support patients in their decision-making. Additional training of GPs may enhance awareness of the possible benefits of abortion counselling for the patients.

**Key words:** Abortion, counselling, GP, reproductive health, termination of pregnancy, women's health.

## Introduction

One of the most important reproductive health indicators is the frequency of terminations of pregnancy (1,2). The rate of terminations of pregnancies is related to legislation and attitudes toward termination in society. Low rates are generally associated with good access to a problem-focused approach to sexuality education, high-quality sexual reproductive health services, easy access to contraception and appropriate use of effective contraceptive methods (3). Although reliable contraceptive methods are accessible and widely used in the Netherlands, one in five

Dutch women report an unintended pregnancy at some point in their lives (4). Most of these unintended pregnancies (68%) are unwanted pregnancies and are terminated for that reason (4,5).

Of all Dutch pregnant women, 13% opt for a termination of the pregnancy and 87% carry the baby to full term (6). The Dutch abortion rate is among the lowest in Europe. In recent years, it has fluctuated around a level of 8.5–8.7 per 1000 women aged 15–44. In 2012, the abortion rate was 8.5 per 1000 (7). Among Dutch women, the highest abortion rate is

found among women aged between 20 and 24 years (15.4 per 1000) and women of Dutch Antillean origin (6). Of all abortions carried out in 2012, approximately one third were performed on women who underwent a previous termination (7). The demographic characteristics of women who have multiple abortions are similar to the risk factors for having one abortion, indicating no additional risk factor for undergoing multiple abortions compared to a single abortion (8).

Abortion services are available without cost for all women living in The Netherlands. The Dutch law (Termination of Pregnancy Act, originally enacted in 1981 and last updated in 2010) enables women to access abortion services without a referral from their GP (9). Nevertheless, the GP is usually involved in the decision-making concerning an unintended or unwanted pregnancy. The GP is in most cases the first person to counsel the patient and support her in the decision-making process. For the termination procedure itself, the woman is referred to one of the abortion clinics in the country. For 6 out of 10 women who have a termination, the GP has referred them to the clinic. In all other cases, a medical doctor from the abortion clinic will take up the counselling task (7).

The Termination of Pregnancy Act requires a 5-day reflection period between the first contact with a medical doctor (who may be the GP) and the actual termination. Such a reflection period is not required in most other countries (10). During the first consultation, the woman must be informed about possible alternative solutions. Both the pregnant woman and the doctor are responsible for the decision process. The woman has to decide herself, free of coercion. The doctor assesses whether the woman has taken her decision after appropriate counselling and careful consideration (11).

The role of GPs in termination of pregnancy counselling is prominent, but there are no official guidelines or protocols that GPs can follow when counselling a patient who requests a termination. A qualitative exploratory study among 12 GPs showed that they used various criteria to assess the validity of the choice made by the women (12). The criteria included the woman's age, the extent to which the choice was made voluntarily and the amount of social support the woman receives. Characteristic for these counselling contacts was that it was the woman who took the initiative; she determined what was discussed. Most doctors did not provide information about alternatives for the termination unless the patient requested it. The GPs reported that views about the patient's autonomy, the termination procedure itself and how to execute their professional role were important considerations during counselling in relation to the termination decision-making process. GPs themselves were ambivalent about whether counselling guidelines should be developed.

In 2005, the Dutch abortion law was evaluated and from this study, it is known that not many women do change their decision due to counselling. Visser *et al.* (11) found that only

1 out of 255 women undergoing abortion who had had introductory counselling consultation at a termination clinic changed their minds and decided against having an abortion. Of course, it is not a goal in itself of counselling to change the decision of a woman when she presents herself for a termination of pregnancy but rather to confirm her initial intention and make sure that the decision-making process included all relevant elements related to a termination of pregnancy decision. It is important to study unwanted pregnancy counselling from the perspective of the outcome for the women because it reflects the decision-making that is involved. The purpose of this study is to provide more information on GPs' actual role in the decision-making process when consulted about unwanted pregnancy. With this information, it may be possible to fill the knowledge gap of GPs in relation to counselling a termination of pregnancy decision and to support evidence-based guidelines.

The research addressed the following questions:

- What are the actions and interventions undertaken by the GP during consultations concerning unwanted pregnancy?
- To what extent do women alter their decision after consultation with their GP concerning their unwanted pregnancy?
- What are the differences in the elements of counselling when women initially choose to have a termination, when they want to carry the pregnancy to full term or when they are undecided?
- Is there a relationship between GP-reported elements of counselling and whether women change their minds? And if so, what is the relationship?

## Methods

Data were collected from GPs participating in the NIVEL Primary Care Database, Sentinel Practices (2004–10). The Sentinel Practices have existed since 1970 and are nationally representative for gender, age, geographic distribution and population density, covering about 0.7% of the total Dutch patient population (13). The number of participating practices varied from 39 to 46 per year in the period between 2004 and 2010, with an average of 43 practices per year. Together these practices offer primary medical care to a total of 134 000–145 000 patients.

All GPs of the Sentinel Practices reported weekly the incidence of a broad variety of illnesses, incidents and interventions. In general practice, data are collected by means of electronic medical records (EMRs). From 2004 to 2010, GPs were asked to keep a weekly record of all patients who consulted them for counselling concerning an unwanted pregnancy by applying a specific International Classification of Primary Care (ICPC) code (ICPC W79) in their EMR (14). In an additional standardized registration form, GPs were asked to record (i) standard demographic characteristics of the patient, (ii) the gestational duration of the pregnancy, (iii) the number of prior pregnancies

and abortions, (iv) the proposed decision concerning the unintended pregnancy and (v) the actions and interventions that were undertaken by the GP (confirmation of the pregnancy by a pregnancy test, discussion of alternative solutions, referral of the patient to specialized counselling, referral of the patient to an abortion clinic and scheduling a follow-up consultation). Approximately 6 months after the first consultation, the GP completed a follow-up questionnaire about the final decision of the patient concerning the pregnancy.

## Analyses

SPSS 19.0 was used for all analyses. Preliminary descriptive analyses were used to describe the background of the patients and the interventions performed by the GPs. To assess differences between the initial choice of the women and interventions that were performed by the GPs, binary chi-square analyses were carried out. In addition to whether findings were significant, their effect sizes (Cramer's *V*) were taken into consideration. After preliminary descriptive analyses, bivariate logistic regression analyses were performed to analyse the relationship between single predictors and the changing thoughts of women concerning their unwanted pregnancy. The predictors that were taken into consideration were age, ethnicity, having children, previous experience with abortion, gestational duration of the pregnancy, discussion of alternative solutions, referral to a specialized institution for counselling, referral of the patient to an abortion clinic, scheduling a follow-up consultation and receiving other interventions by the GP. Following this, the individual contribution of all significant variables was examined in a multivariate logistic regression. Statistical significance level was determined at 0.05.

## Results

### Demographic characteristics

Overall, 770 patients consulted their GP concerning an unwanted pregnancy during the observational period. In total, 103 cases were excluded from the study since the proposed decision concerning the unintended pregnancy was unknown or the final decision was unknown due to the fact that the GP had stopped working, the patient had moved or for other reasons. After these exclusions, 667 pregnant women were suitable for analyses with a mean age of 27.8 years (Table 1). Most women were of native Dutch origin or had a western background and lived with a partner. Half of the women were childless; a fifth (18.2%) had one child, 18.6% had two children and the other 13.3% had three to six children. More than a quarter of the women had an unwanted pregnancy before and one in five women had a prior abortion. At the time of the first consultation, the average gestational duration was 6.7 weeks (SD = 3.2). One in five (20.3%)

women consulted their GP within the first 4 weeks of their pregnancy, 96.7% within the first trimester (1–13 weeks).

### Initial and actual outcome of the pregnancy: changing thoughts

The great majority of the women (84%) had decided about their unwanted pregnancy before the first GP consultation (Table 2). Of these women, 80% planned to have a termination, 5% wanted to keep the baby and none of the women intended to give the baby up for adoption. A group of 16% was undecided concerning their pregnancy. Five per cent of the women eventually had a miscarriage. The majority of the women who were undecided during the first consultation decided to have an abortion (59%; *N* = 62), over a third kept the baby (33%;

**Table 1.** Characteristics of the study sample (*N* = 667)

	<i>n</i>	%
Ethnicity		
Dutch/Western	391	69.0
Non-Western	176	31.0
Living situation		
With a partner	276	57.3
Without a partner	206	42.7
Children		
Childless	329	49.8
Have children	331	50.2
Prior unwanted pregnancy		
No	469	71.9
Yes	183	28.1
Prior abortion		
No	507	78.1
Yes	142	21.9
	Mean	SD
Age (years)	27.8	8.0
Gestational duration (weeks)	6.7	3.2

**Table 2.** Original intention and actual outcome of pregnancy (*N* = 667)

Initial intention	Actual outcome				Total
	Abortion	Keep the baby	Adoption	Miscarriage	
Abortion	474 71.1%	34 5.0%	1 0.1%	23 3.4%	532 79.8%
Keep the baby	5 0.7%	20 3.1%	0 0%	4 0.6%	30 4.5%
Undecided	62 9.3%	35 5.2%	1 0.1%	7 1.0%	105 15.7%
Total	541 81.1%	90 13.5%	2 0.3%	34 5.1%	667 100.0%

$N = 35$ ), one woman opted for adoption and 7% ( $N = 7$ ) had a miscarriage.

In order to know how many women changed their minds after the first consultation with their GP, analyses were carried out among those women who were decided about their pregnancy during the first consultation and who did not subsequently have a miscarriage ( $N = 535$ ). Of this sample, 93% maintained their initial decision: 89% had an abortion and 4% kept the baby. A total of 8% ( $N = 40$ ) changed their minds. Of the women who initially wanted to have an abortion ( $N = 509$ ), 7% ( $N = 35$ ) eventually decided to keep their child. In one case, the pregnancy was carried to term, but the child was offered for adoption. Among women who had initially decided to keep their child ( $N = 26$ ), five eventually had an abortion.

### Elements of GP counselling in relation to the initial choice of the women

Analyses of GP's interventions for each initial choice of the women show that most women (72%) are referred directly to an abortion clinic, including two participants who originally intended to keep the child (Table 3). Women were rarely referred for specialized counselling, mainly when they had not yet decided on a course of action. More than one out of four women had a pregnancy test, independent of their initial intention. GPs discussed alternative solutions with only 21% of their patients. They were most likely to do this with women who were undecided. When an abortion was intended, alternatives were less likely to be discussed. GPs performed other interventions (e.g. carried out an ultrasound, arranged referral to a gynaecologist, psychologist or social worker or provided information about contraception) mainly with patients who wanted to keep the baby. Of the women who expressed their wish for a termination, 86% were referred to an abortion clinic without having discussed alternative solutions. Of the undecided women 24% was referred to an abortion clinic without discussing alternative options. (not in Table 3, additional calculation).

### Changes in decision-making in relation to GP counselling

Bivariate analyses (Table 4) show that there were no other socio-demographic differences between women who changed their minds and those who did not. On average, women who changed their minds were pregnant longer than those who pursued their initial choice. They were also more likely to have discussed alternatives with their GP and have scheduled a follow-up consultation. On the other hand, women who were referred to an abortion clinic were unlikely to change their minds.

In the multivariate regression analysis, only the four significant variables were entered into the model. The sample contained a sufficient number of women who altered their decision to justify the use of this regression model (15). The effect of follow-up consultation disappears when controlled for the other GP interventions and the duration of the pregnancy. Gestational age, discussion of alternative solutions and referral to an abortion clinic remained related to whether or not a woman had changed her mind (Table 4). The highest odds ratio was found for discussing alternatives; those who had discussed alternatives with their GP were four times more likely to change their mind than those who had not. The model explains 17% of the total variance (Nagelkerke  $R^2$ ).

### Discussion

Most women who consult their GPs for unwanted pregnancy opt for an abortion and do not change their minds. A small proportion of 5% initially intends to keep the baby and one in six is undecided. Of the women who have made up their minds at the initial consultation, 8% altered their decision after consultation with their GP. Of the women who ultimately carry to full term, more than half initially wanted to terminate their pregnancies. Women who changed their mind had a longer duration of gestation and were more likely to have discussed alternatives with their GP. Women who were referred to an abortion clinic were more likely to maintain their initial decision. Only 41% of those

**Table 3.** Interventions performed by GPs according to initial intention (%)

	Abortion ( $n = 532$ )	Keep the baby ( $n = 30$ )	Undecided ( $n = 105$ )	Total ( $n = 667$ )	Cramer's V
Interventions					
Pregnancy test	25.6	30.0	36.2	27.4	0.09
Discussion of alternative solutions*	16.9 ▼	23.3	41.0 ▲	21.0	0.21
Referral to an abortion clinic*	84.2 ▲	6.7 ▼	27.6 ▼	71.8	0.55
Referral to a specialized institution for counselling*	3.2 ▼	3.3	15.2 ▲	5.1	0.20
Scheduling a follow-up consultation*	22.0 ▼	36.7	65.7 ▲	29.5	0.35
Other interventions*	9.0 ▼	50.0 ▲	20.0 ▲	12.6	0.29

▲/▼ = percentage is significantly higher/lower than the overall percentage,  $P < 0.05$ , Cramer's  $V > 0.10$ .

\*Significant ( $P < 0.05$ ) difference between subgroups in percentage of received interventions by GP.

**Table 4.** Bivariate and multivariate logistic regression predicting change of decision; odds ratios and 95% confidence intervals

Characteristic	Bivariate	Multivariate
Age	0.96 (0.92–1.00)	na
Ethnicity		
Dutch/Western (ref)	1.00	na
Non-Western	0.67 (0.31–1.47)	
Living situation		
Without a partner (ref)	1.00	na
With a partner	0.83 (0.41–1.71)	
Children		
Childless (ref)	1.00	na
Have children	0.53 (0.27–1.04)	
Prior abortion		
No (ref)	1.00	na
Yes	1.03 (0.49–2.18)	
Gestational duration (weeks)	1.15 (1.07–1.23)**	1.13 (1.04–1.22)**
Interventions by GP		
Discussion of alternative solutions	4.44 (2.27–8.67)**	3.72 (1.84–7.50)**
Referral to an abortion clinic	0.28 (0.14–0.54)**	0.41 (0.19–0.87)*
Referral to a specialized institution for counselling	1.81 (0.40–8.25)	na
Scheduling a follow-up consultation	2.15 (1.10–4.22)*	1.55 (0.73–3.30)
Other interventions	1.93 (0.81–4.60)	na
Nagelkerke R <sup>2</sup>	–	0.165

Figures in parentheses are 95% confidence intervals. na, not analysed; ref, reference category.

\* $P < 0.05$ , \*\* $P < 0.01$ .

women who were undecided were counselled about considering alternatives. Of the women who indicated they wanted a termination, five out of six were referred to an abortion clinic without having discussed alternative solutions.

Most women who changed their minds kept the baby, possibly because of the longer duration of the pregnancy, causing more ambivalence (16). Terminations are more controversial when the pregnancy has progressed further (17).

It is reasonable to assume that women who are very decisive in their desire for a termination require fewer interventions by the GP. However, providing information about alternatives is legally required before a pregnancy may be terminated (Wet Afbreking Zwangerschap/Termination of Pregnancy Act, art. 5-2a). Adequate support has also been shown to minimize the psychological consequences for women undergoing abortion (18). The large percentage of women who do not receive information on alternatives may therefore be worrying, particularly among those women who are undecided when they consult their GPs. Even though they discuss alternatives with their GPs, more often than the women whose initial decision was an abortion, 60% of these women do not receive adequate counselling.

### Strengths and limitations of the study

To our knowledge, this is the first quantitative study in the Netherlands about GPs' interventions during consultations about

unwanted pregnancy. The network of Dutch Sentinel Practices used in this study is nationally representative for the Dutch general practice population, which is a major strength. The study is representative for the average Dutch general practice patient population with regard to age, regional distribution and population density. Another strength is the use of a long-standing GP network, reducing the chance of a non-responder bias.

The study is based on questionnaires completed by the GP, which are not comprehensive reports of the patient–doctor consultation. The self-report may be biased by what GPs think about their patients' pregnancy, induced abortion and what they themselves perceive to be the right approach. However, we would have expected more frequent discussion of alternatives for induced abortion if social desirability played an important role. There is no indication that selective underreporting occurred for unwanted pregnancies (13).

A problem in relation to the data analyses of this study was the low number of women who changed their minds during the study period. This happened in only 40 cases where only five women had an abortion after first intending to keep the baby. Therefore, we could not analyse this latter group separately from the group that decided to carry the pregnancy to full term contrary to their earlier intention. In addition, the high number of bivariate analyses can lead to a substantial increase in the chance of a Type I error. This means that some of the statistically significant predictors related to a change of mind could result

from chance. However, the value of these findings is put to the test in the multivariate analysis where each is controlled in relation to the other significant factors.

### Comparison with existing literature

From research in the USA, it is known that women prefer to be counselled regarding a termination and to even have this carried out as part of primary care (19,20). However, there is little information about the role of the GP in decision-making concerning unwanted pregnancy. Zijp-Zuidema *et al.* (12) indicate that GPs in the Netherlands sometimes fail to guide their patients to making an informed choice. Based on interviews with 12 GPs, they conclude that GPs highly appreciate patient's autonomy and freedom of choice. Our study is consistent with these findings. We therefore suggest that Dutch GPs play a more proactive role in the counselling of unwanted pregnancy and that opportunities are created for training in this subject.

In a study evaluating the Dutch Termination of Pregnancy Act, practitioners in clinics and hospitals performing abortions were asked what they consider to be the tasks of the referring doctor. The most frequently mentioned tasks were confirmation of the pregnancy, establishing the official start of the 5-day 'reflection period', informing the patient about the medical procedure, providing psycho-social support to the patient, providing information about contraception and supporting the women in their decision-making process (11). Some GPs were oblivious to the fact that a consultation with a GP marks the official start of the 5-day reflection period. They failed to transmit valuable information to the doctor who would perform the termination such as the date of the first consultation. Furthermore, 30% of the women undergoing abortion would have liked more information from their referring doctor, especially concerning the steps involved in having an abortion. Visser *et al.* (11) recommend additional training for GPs in order to increase their knowledge on the Dutch abortion law and abortion procedures.

### Unanswered questions and suggestions for further research

A follow-up study with a larger sample size may show changes over time and enable one to distinguish between those women who change their decision from abortion to keeping the baby and *vice versa*. If both GPs and their patients could be used as informants, such a study would gain depth and reliability. Furthermore, the multivariate regression model explained only 17% of the variance of changes in decision-making. Apparently other factors are important as well. In order to explore these factors, qualitative studies may generate hypotheses and provide insight into what is discussed during consultations and what women themselves consider important in making the decision of whether or not to

terminate their unwanted pregnancy. Finally, it would be interesting to evaluate not only the content of what is being discussed but also patients' satisfaction about the process. How helpful is the information that is provided and how satisfied are the women in question with the decision-making support they receive?

### Conclusion

GPs are not obliged to assume the task of abortion counselling and may delegate this task to the abortion clinic. More standardized consultation in relation to unwanted pregnancy could be adopted in order to ensure that all the possible options are evaluated. Additional training may enhance awareness of the possible benefits of more extensive counselling for the patients. A recent qualitative study on abortion counselling training for family medicine residents in the USA showed the benefits of offering such a training (21). Postgraduate training of GPs could integrate training on counselling women with unwanted pregnancies.

### Acknowledgements

We would like to thank all GPs from the Dutch Sentinel General Practice Network for their contributions to the study. We thank Marianne Heshusius for her crucial role in the data collection process.

### Declaration

Funding: Dutch Primary Care Database was funded by the Ministry of Health.

Ethical approval: not required under Dutch Law as the study used only anonymous data collected by routine surveillance. In addition, the respondents were not submitted to any medical interventions other than standard practice.

Conflict of interest: none.

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