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Abortion

Women's Experiences Using Telemedicine to Attend Abortion Information Visits in Utah: A Qualitative Study

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A B S T R A C T

Introduction: Utah requires abortion patients to wait at least 72 hours between attending mandatory information sessions and having an abortion. In 2015, Planned Parenthood Association of Utah began offering telemedicine as a way for patients to attend state-mandated information visits. The purpose of this study was to evaluate patients' experiences using telemedicine to attend abortion information visits.

Methods: Between April and October 2017, we conducted 18 in-depth interviews with women who used telemedicine to attend state-mandated information visits. Interviews were qualitatively analyzed using iterative thematic techniques to identify themes related to experience and acceptability of telemedicine to attend information visits.

Main Findings: Women reported telemedicine helped to minimize the burdens of cost, travel, and time associated with attending two in-person visits. Those who lived near a clinic that offered in-person information sessions reported the additional benefit of maintaining privacy by not being seen at the clinic. Overall, women reported that telemedicine was easy to use and felt the nurse was attentive to their emotions over video. A minority of women said they would have preferred an in-person visit, but the burdens of attending in person led them to choose telemedicine.

Conclusions: The findings from this study indicate that telemedicine is highly acceptable to patients as a mode of attending state-mandated information visits for abortion. Although telemedicine does not eliminate the logistical and financial burdens previously found to be associated with Utah's 72-hour waiting period and two-visit requirement, telemedicine may reduce the burdens associated with two-visit requirements for abortion and should be adopted in states that require face-to-face information sessions.

Access to timely abortion care is critical to women's reproductive health. State-based restrictions on abortion in the United States, such as mandatory waiting periods, can delay care, interfere with provider–patient relationships, and impose medical, social, and economic burdens on women (Baum, White, Hopkins, Potter, & Grossman, 2016; Fuentes et al., 2016; Grossman et al., 2014; Ostrach & Cheyney, 2014; Roberts, Fuentes, Kriz, Williams, & Upadhyay, 2015; Roberts, Turok, Belusa, Combellick, & Upadhyay, 2016). Thirty-four states require that women complete an informed consent and disclosure visit (or information visit) before an abortion is performed; 27 of these states require women to wait a specified amount of time, most commonly 24 hours, between the information visit and the abortion procedure (Guttmacher Institute, 2019). Further, 14 of these states require that the information visit occur in person, necessitating at least two separate visits to the clinic (Guttmacher Institute, 2019).

A recent report by the National Academies of Sciences, Engineering, and Medicine concluded that mandated waiting periods diminish the quality of abortion care by interfering with timeliness, effectiveness, and equity, three of six attributes that define health care quality (The National Academies of Sciences, Engineering, and Medicine, 2018). Studies show that two-visit requirements are associated with out-of-state travel for

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abortion and increases in the proportion of abortions performed in the second trimester (Joyce, Henshaw, & Skatrud, 1997; Joyce, Henshaw, Dennis, Finer, & Blanchard, 2009). They are particularly burdensome for women who live far from an abortion provider or who need to arrange childcare, transportation, and time off of work (Roberts et al., 2016; Sanders, Conway, Jacobson, Torres, & Turok, 2016; White et al., 2018). Some argue that waiting periods provide women time to be sure of their decision. Yet, evidence suggests that women rarely change their minds after presenting for abortion care or regret their decision (Cameron & Glasier, 2013; Foster, Gould, Taylor, & Weitz, 2012; Lupfer & Silber, 1981; Ralph, Foster, Kimport, Turok, & Roberts, 2017; Rocca et al., 2015). One study found that women seeking abortion in Utah were as or more certain about their decisions compared with men and women making other health care decisions (Ralph et al., 2017).

In May 2012, Utah became the first state to require a waiting period as long as 72 hours (Guttmacher Institute, 2019; Roberts et al., 2016). Information visits must occur face to face and are offered at eight Planned Parenthood–affiliated clinics and one private abortion clinic in the state. They may also be offered by any private provider, but few seem to provide this service (Sanders et al., 2016). The state's two abortion clinics are located in Salt Lake City; thus, nearly two-thirds of Utah women of reproductive age live in counties without an abortion provider (Jones & Jerman, 2017). Evidence indicates that Utah's waiting period increases costs, logistical hassles, stress, and delays, but does not result in many patients deciding to continue their pregnancies (Roberts et al., 2016; Sanders et al., 2016).

Telemedicine, the delivery of health care services at a distance using information and communication technology, has become an increasingly integral part of health care provision, including for abortion. Over the past decade, abortion providers have begun using telemedicine with videoconferencing to deliver information and to administer medication abortion services remotely. A study in Iowa found that telemedicine provision of medication abortion was safe, effective, and well-liked by patients (Grindlay, Lane, & Grossman, 2013; Grossman & Grindlay, 2017; Grossman, Grindlay, Buchacker, Lane, & Blanchard, 2011). It was also associated with a decrease in second trimester abortions, suggesting that telemedicine may enable early access to services, when risks and costs are lower (Grossman, Grindlay, Buchacker, Potter, & Schmertmann, 2013). Planned Parenthood Association of Utah (PPAU) began using telemedicine to complete Utah's mandated information visit in January 2015. Telemedicine used for information visits involves receiving state-mandated information about pregnancy and abortion from a health care provider during a live, interactive videoconference session. This model of synchronous videoconferencing uses a direct-to-patient model, where patients are connected to a health care provider through their personal devices. The purpose of this study was to describe women's experiences using telemedicine for their abortion information visits, including their perceptions and reactions to Utah's mandated waiting period and information visit.

Methods

Our study sites included one PPAU clinic that provided abortion care in Salt Lake City and seven PPAU-affiliated clinics that provided information visits but not abortion care. Information visits could be completed via telemedicine or in person at any of PPAU's eight clinic sites. Visits attended by telemedicine were one on one with a health care provider, and in-person visits were typically conducted in a group setting. Patients who chose telemedicine for the information visit when they called to schedule their abortion received an appointment time and sign-in instructions to a secure online portal, where they were joined in videoconferencing by a nurse who read aloud a state-mandated script and answered the patient's questions.

Between May and October 2017, PPAU staff recruited abortion patients during their telemedicine or in-person information visits to complete a self-administered online survey about their experience with the visit. The survey additionally collected participants' demographic information, which included age, race, ethnicity, and level of education. Eligible survey participants were age 18 or older and spoke English or Spanish. At the end of the survey, those who indicated that they used telemedicine for their information visit were asked if they were willing to be contacted to participate in an in-depth interview using the contact information they provided. The interview guide, which included open-ended questions about their experiences using telemedicine, was semistructured and modeled after those used in studies of patients accessing medication abortion via telemedicine (Grindlay & Grossman, 2017; Grindlay et al., 2013). We aimed to conduct up to 20 interviews to achieve saturation and obtain a range of perspectives.

Researchers attempted to contact eligible and interested participants up to three times by phone or email to schedule an interview. Interviews were conducted over the phone on average 3 weeks after participants attended their information visits via telemedicine. All participants provided verbal consent to participate and to be digitally recorded. Interviews ranged in length from 30 to 75 minutes. Participants received a $50 gift card for participating in the interview. This study was approved by the Institutional Review Board at the University of California, San Francisco.

All interviews were transcribed verbatim and coded in Dedoose 8.0.35 by two coders. A codebook was developed by the coders based on topics in the interview guide and themes that emerged from the interviews. The first and second coders independently coded three interviews and afterward discussed discrepancies and revised the codebook. The first coder coded the remaining interviews. Interviews were analyzed using an iterative thematic analysis and illustrative quotations were selected for inclusion in this article. Our thematic analysis was framed around participants' experiences using telemedicine as a service delivery model as well as participant satisfaction with this model. We also examined participants' opinions on Utah's state-mandated waiting period and information visit requirement. Participants are identified in this text by identification number, distance from PPAU's abortion clinic, and pregnancy outcome.

Results

Participant Characteristics

We completed 18 interviews in English with eligible participants between April and October 2017. Thirty-two participants were interested in an interview and were contacted. Twenty-two participants responded, among whom one declined to participate and three were deemed ineligible because they had attended in-person information visits. Two of those ineligible participants initiated interviews before it became clear that they

had not completed a telemedicine visit and were excluded from this analysis. We determined the 18 interviews conducted covered a range of perspectives and experiences and had achieved saturation of key themes.

Participants ranged in age from 19 to 40 years old (Table 1). The majority of participants had children who lived with them; five participants had never been previously pregnant. Only three participants reported having had a previous abortion. All but two participants reported working outside of the home, and two participants were working and attending school. Two participants continued their pregnancies and one reported having a miscarriage. The remaining 15 participants had an abortion at the clinic.

Participants lived an average of 126 miles (range, 9–280 miles) from the PPAU abortion clinic and an average of 87 miles (range, 2–269 miles) from the nearest clinic that provided information visits. More than one-third of participants lived more than 200 miles from the abortion clinic. One participant (ID 8) was on a road trip and did not have a travel distance to report. Seven participants (IDs 1, 2, 4, 7, 8, 10, and 11) lived out of state. The average time between information visits and abortion appointments was 10 days (range, 5–17 days) among the 17 participants who scheduled abortions.

Reasons for Choosing Telemedicine

The primary reason reported for choosing telemedicine was convenience. When asked to describe what convenience meant for them, participants listed factors related to cost and scheduling, regardless of their distance from the clinic. Privacy was an additional benefit, mainly reported among participants who lived near a clinic.

Cost and scheduling

Women commonly referred to the costs they avoided by choosing telemedicine, including lost income, gas money, and childcare expenses. One woman said that if she had not had the telemedicine option, she would have stayed in the city for the duration of the waiting period to avoid traveling back and forth:

> For me, not living in the city where it's available, that would have been really complicated. I would have had to take not only the day or two off of work for the abortion, but I would have also taken the 72 hours after the [information] appointment. So up to a week. That would have been pretty detrimental to me monetarily. And, at my job if I couldn't get that much time off, I would've had to wait even longer [for the abortion], right? … Having that option was really, really, really helpful. (ID 6, 250 miles, continued pregnancy)

Many participants said that using telemedicine allowed them to schedule their appointments over their lunch break and still attend a full day of work. Several women said the availability of telemedicine meant they could schedule an information visit sooner, in some cases that same day. One woman explained:

> I would have [had] to take off several hours to do [an in-person information visit], or even a whole day, when I could have just taken 20 minutes away from the job to just do it on the internet, or on my phone or whatever. So I think it's a great opportunity for anybody, no matter where they are. (ID 5, 250 miles, surgical abortion)

Table 1
Summary of Participant Characteristics

ID	Age (y)	Race/Ethnicity	Highest Completed Education	Previous Abortion(s)	Distance Participant Lived from Abortion Clinic in Salt Lake City (Miles)	Days Between Telemedicine and Scheduled Abortion Appointment	Pregnancy Outcome	Gestational Age (wk)
1	35–39	White	Professional or advanced degree	Yes	215	8	Surgical abortion	≤10
2	20–24	White	Some college	No	280	7	Surgical abortion	≤10
3	35–39	White	Some college	No	32	6	Medication abortion	≤10
4	25–29	Native American	High school degree or GED	No	272	N/A	Continued pregnancy	N/A
5	25–29	White Hispanic	College degree	No	250	8	Surgical abortion	≤10
6	25–29	White	College degree	No	250	8	Continued pregnancy	N/A
7	25–29	White/Pacific Islander	Professional or advanced degree	No	125	11	Surgical abortion	>10–15
8	25–29	White Hispanic	College degree	Yes	N/A	12	Surgical abortion	≤10
9	18–19	White	High school degree or GED	No	106	7	Medication abortion	≤10
10	20–24	White Hispanic	Less than high school	No	10	8	Surgical abortion	>10–15
11	25–29	Black or African American	Some college	No	170	15	Surgical abortion	≤10
12	35–39	White	Professional or advanced degree	No	217	17	Surgical abortion	>10–15*
13	25–29	Asian American or Pacific Islander	College degree	No	9	8	Medication abortion	≤10
14	25–29	Black or African American	High school degree or GED	No	32	5	Surgical abortion	>10–15
15	40–44	White	College degree	No	9	8	Miscarriage	N/A
16	35–39	White	Less than high school	Yes	11	10	Surgical abortion	≤10
17	18–19	White Hispanic	Some college	No	253	16	Surgical abortion	>10–15*
18	30–34	White	College degree	No	26	8	Medication abortion	≤10

* Participant reported being >10 weeks and did not report attending an additional clinic appointment for cervical preparation, so gestational age is assumed to be ≤15 weeks.

Most participants were frustrated that they had to travel significantly further for abortion than for other health care. Although all women described the convenience of telemedicine, those with longer travel distances reported having avoided extreme logistical hassles associated with planning two in-person appointments. Most participants were previously unaware of Utah's two-visit requirement. When asked how they felt things could have been different if they had to attend the appointment in person, many said the unexpected travel coordination to schedule an in-person information visit would have delayed their abortions further. Women living in neighboring states to Utah said they chose to access their abortion in Salt Lake City because the availability of telemedicine meant they would only be required to attend one appointment in person, compared with multiple appointments in their home states. A woman described:

> In Idaho it takes no less than three visits [and] the closest [for me] to one in Idaho is two hours [away]. … Doing the telemedicine and being able to combine the ultrasound with the procedure [was better than] more visits driving two hours one way and two hours back. … You really don't have the access, and the choices are really limited. (ID 12, 217 miles, surgical abortion)

Privacy

Among women who lived near clinics where information sessions were offered, privacy was a common reason for choosing telemedicine. Some of these women said they did not want to be seen at the clinic and were not comfortable with an in-person group visit, and that telemedicine allowed them to be alone with the nurse. One woman, who told us she lived near an abortion clinic in another state, chose to access abortion care in Utah because it was the next closest option and would allow her to avoid being seen at the clinic. She said it would be "detrimental" to her if anyone from the community knew about her pregnancy, yet traveling to Utah for two in-person visits would not have been possible. She said about telemedicine:

> You can do it in your own home. You can do it in your own privacy. You don't have to worry about, you know, going to the parking lot, walking in, and having, you know, Miss Susan the neighbor walking by with her dog and seeing you walk in.… So there are lots of pros to [telemedicine]. (ID 2, 280 miles, surgical abortion)

Another participant explained when asked what she liked about telemedicine:

> First of all, the privacy, where you're not walking into a clinic, that's a big thing with me. I'm a professional woman and I'm … just embarrassed by the whole thing. (ID 15, 9 miles, miscarriage)

Before learning about the option to use telemedicine, one participant scheduled an information visit at her local clinic but decided not to attend, partly over fear of being recognized:

> The first [information] appointment that I had, I didn't have the money for, and I also just kind of chickened out because it was right next to where I live. I know a lot of people in the area, and I really just didn't want to show up at a class where I was going to know people and have people know what I was going through. So, I called back after I had already missed that appointment … and then the lady told me about the app that you could do the visit on from home. (ID 10, 10 miles, surgical abortion)

Another woman explained that to attend two appointments in person, she would have potentially disclosed private information to arrange childcare:

> Yes, [an in-person information visit] would have been harder because I would have had to tell somebody, like, because my babysitter lives right next door to my work, so she would have obviously known that I wasn't at work. And so I would have had to try to explain to her where I was going, that I wouldn't be around. Yeah, I think probably the only thing that would have been different was childcare. Kind of a pain. (ID 7, 125 miles, surgical abortion)

No women in our study reported concerns that telemedicine would be less private than attending an information visit in person.

Experience Using Telemedicine

The vast majority of participants did not know about Utah's waiting period requirement before calling Planned Parenthood, when they also learned about the option for telemedicine information sessions. Participants commonly reported thinking that telemedicine was a good use of technology. The participant who lived the furthest from the abortion clinic said:

> I thought [telemedicine] was a great option. Especially for other women like me, where we're not very close to places that do this in a safe way. So I thought that was a great way to be … able to have others from other areas come and have this. (ID 2, 280 miles, surgical abortion)

Others worried telemedicine would be difficult to use and were surprised that it was simple and straightforward. Most participants reported attending the telemedicine visit from their homes using a laptop or smartphone; some said they completed the visit from the breakroom at work, their car, or while on a walk. One woman said, "I thought it was very progressive. I'm like, 'Do I even have something capable of doing this? Yeah, I guess my cellphone.' I thought that was cool" (ID 18, 26 miles, medication abortion).

Participants commonly described feeling relieved they had chosen to use telemedicine once they completed the information visit and understood what it entailed. One participant said:

> I don't think it would be any more effective doing that in person than via teleconference because it's just an informational thing. So, it was convenient to do the teleconference, and I prefer that than driving 30 miles to meet with somebody in person. (ID 3, 32 miles, medication abortion)

Some women reported that they expected attending the information appointment in person would have made them more anxious about a decision they had already made. One woman said, "I probably would've had a little more anxiety building up to it. … I feel like in your house it's a lot more comfortable" (ID 9, 106 miles, medication abortion). Another woman said she expected she would have faced similar burdens to attending an in-person information visit as she did her abortion appointment:

> I wouldn't have liked [an in-person information visit].… I'd have to basically go through that again. The whole waiting,

being alone, being in public again.… I wouldn't have felt as comfortable as I did with the [appointment] online. (ID 2, 280 miles, surgical abortion)

Several participants said they were worried the information visit would be awkward, either because of its content or because telemedicine as a mode of delivering the information would be "weird," or both. Many described feeling relieved that the nurse was "friendly" and "nonjudgmental" over video. One woman said: "[The nurse] was very personable and very straightforward and kind of funny, and really kind of put me at ease through the whole thing" (ID 12, 217 miles, surgical abortion). Some women said that they liked seeing the nurse over video because they could make eye contact and see that she was alone.

And I could see that she was sitting in a room by herself, which was also nice. You know what I mean? Because you never know who's listening or is there. Especially with a discussion like that. (ID 15, 9 miles, miscarriage)

The one participant who did not schedule an abortion after her telemedicine appointment reported that she was ambivalent about having an abortion and that the mandated script did not help her make a decision. She said the nurse could still sense her discomfort without being in the same room, and helped her to come to a decision that was right for her:

I don't know if you guys ever find the nurse that I talked to. But, she really helped me just in that little [way], saying, "You'll know what's best for you." That really just stuck with me, like, saying, "Okay, yeah, I do know what's best for me." (ID 4, 272 miles, continued pregnancy)

Not all participants reported feeling that telemedicine was the best option for them. Two participants (IDs 1 and 6) said they would have preferred an in-person appointment. One woman said, "I think it just would have been nice to actually have met the [nurse]" (ID 1, 215 miles, surgical abortion). To attend in person, she said she would have had to miss a day of work and drive nearly 200 miles one way, which she described as costly.

About one-third of participants reported minor technical difficulties, mainly with regard to sound and video quality. Most participants waited less than 5 minutes before the nurse joined the video call, but a few had wait times of more than 15 minutes and were notified of the delay.

The only participant who reported strongly disliking the telemedicine visit said that she had reluctantly scheduled the appointment because her partner wanted her to have an abortion; ultimately, she decided to continue her pregnancy. She said she felt unable to connect emotionally with the nurse over telemedicine, and suspects she may have also felt uncomfortable at an in-person visit:

The nurse was nice. But she just read me a script, and then I just felt—I mean, personally, emotionally, I didn't feel good about the entire situation. So the whole time she was reading I thought I wanted to cry. And it's awkward, because I'm like not in a situation where that feels appropriate. There's a disconnect online, for sure. There's a disconnect in being read a script and not spoken to. So I felt more like a computer was reading me something, than I was sitting there having a conversation with somebody. And so I didn't feel comfortable to express any emotion. And I honestly didn't even feel comfortable to ask any questions. I didn't like it. …I have a feeling that the in-person visitation would have been sort of similar. Like the nurse would have read me the script and looked at me, in a small, tiny white room, and asked me if I had any questions. And I probably would have swallowed my pride and said, "No." (ID 6, 250 miles, continued pregnancy)

None of the participants indicated that using telemedicine impacted their decision to have an abortion or continue the pregnancy.

Participant Reactions to Information Visit and Waiting Period Requirements

The majority of women said they did not find the content of the information script to be informative. Participants who were conflicted about their abortion decision (IDs 4, 6, and 15) said the script did not help with their decision making and in some cases it had a negative impact. Many also said it felt impersonal or "fake" to be read a script they could have read themselves. Women who found the information visit to be helpful referred to having the opportunity to ask questions, such as the differences between a medication and a surgical abortion.

One woman told us she thought the option to use telemedicine was beneficial in a state like Utah where there is limited access to abortion:

I think that access to [abortion] is very, very important. And I think that if you're going to make a law that people have to go in and talk to somebody, three days before they decide to do something, or whatever, I think the fact they can have a choice to be there in person [or] do it on their computer or the phone, it's really beneficial. (ID 5, 250 miles, surgical abortion)

Women told us the information visit and waiting period laws made access to abortion more difficult and contributed to logistical and emotional burdens. Several women said they would have called sooner if they had known they would be required to wait. One woman said the mandated waiting period affected the type of abortion she was able to have, but did not affect her decision to have an abortion:

I had made up my mind, I just wanted to get it done and over with. And I was really quite frustrated [Utah] has a wait time. … And I feel like if I didn't have the wait time I would have been able to just do the medical abortion and not the procedure… But with the wait time added on, I couldn't. (ID 7, 125 miles, surgical abortion)

Similarly, another woman said:

The 72 hours law is kind of stupid because I had already made my decision. … I knew what I wanted to do, and that whole 72 hours wasn't going to make any difference. (ID 13, 9 miles, medication abortion)

Discussion

Our participants had an overall positive experience using telemedicine for state-mandated information visits and reported that their anticipated burdens of attending two appointments in person were minimized by telemedicine. Women's expectations of logistical hassles and emotional burdens align with previous findings that show the 72-hour waiting period and two-visit requirement in Utah imposes unnecessary burdens on women seeking abortion (Roberts et al., 2016). Participants waited an

average of 10 days between their information visits and scheduled abortions, more than three times longer than the state-required 72 hours. This prolonged wait time is consistent with previous findings from a larger sample of women obtaining abortions in Utah, who waited an average of 8 days between appointments (Roberts et al., 2016).

No participant identified ways that the information visit script and waiting period were beneficial to them personally. Women perceived the information visit mainly as a requirement and in some cases anticipated the visit would be unhelpful or uncomfortable whether conducted in person or via telemedicine. Some endured additional expenses and hurdles owing to these requirements, which delayed their access to care. Although telemedicine does not eliminate the logistical and financial burdens previously found to be associated with Utah's 72-hour waiting period and two-visit requirement, the data presented here suggest that the option to attend information visits via video may significantly decrease these burdens.

Study participants indicated the information visit and two-visit requirement did not change their decision to have, or not have, an abortion, reflecting prior research that women who present for abortion rarely change their minds (Cameron & Glasier, 2013; Foster et al., 2012; Lupfer & Silber, 1981; Ralph et al., 2017; Rocca et al., 2015). Among the three participants who reported feeling ambivalent or conflicted about having an abortion, two chose to continue their pregnancies for reasons unrelated to the information visit script and one had a miscarriage.

Although long travel distances clearly exacerbated burdens accessing abortion care for women living in rural areas, women who lived both near and far from a clinic that provided in-person visits identified similar advantages of telemedicine. However, participants who lived near a clinic offering in-person information visits or that provided abortion services in another state were more likely to describe risks of having their privacy violated by attending in person. The ability for patients to maintain privacy reflects how the option to use telemedicine may enhance feelings of comfort and security among abortion patients. These data suggest the relevance of telemedicine in diverse contexts and for all types of women, not only those who live far from these services.

Women who said that the privacy of telemedicine was important to them mainly described how it helped them to avoid their local clinics. Although these women expressed that this privacy improved their abortion experience, these examples suggest that telemedicine may reinforce internalized or anticipated stigma of abortion for some, as previously found in a qualitative study on telemedicine and medication abortion (Grindlay et al., 2013). Interestingly, our participants did not discuss cybersecurity as a concern related to the telemedicine platform, as previously found among a sample of women receiving medication abortion via telemedicine (Grindlay et al., 2013). Rather, our participants referred to the privacy of telemedicine as a reason they chose, or liked, this method.

Similar to previous findings that telemedicine for medication abortion provision facilitated a more patient-centered approach to care (Grindlay & Grossman, 2017), our participants were highly satisfied with their patient–provider interaction over telemedicine. Although one participant was not satisfied with her interaction, women's descriptions that nurses put them at ease and were attentive to their emotions over video were consistent across all other interviews.

This study has several limitations. We aimed to identify common themes across participants' experiences through qualitative methods, and our findings may not be generalizable to all patients attending information visits via telemedicine. Our study only sampled women who used telemedicine, and we are unable to make a comparison between telemedicine and in-person visit experiences. Telemedicine patients volunteered to participate in an interview, creating the potential for self-selection bias and censoring of patients who had negative experiences. Despite these limitations, these data provide in-depth information on patients' experiences using telemedicine to attend state-mandated information visits, an area previously unexamined.

Implications for Practice and/or Policy

This study indicates that women were highly satisfied with their experiences using telemedicine for information visits and that telemedicine aided in decreasing anticipated burdens associated with the cost, travel, and social consequences for our participants. Telemedicine may not be the preference for all women, and it is important to provide both telemedicine and in-person options when possible. Our findings have implications for other states that have state-mandated information visits and waiting periods, suggesting that telemedicine could allow abortion patients to fulfill these requirements and decrease some of the burdens of multiple in-person visits. The use of telemedicine for abortion care clearly extends beyond the provision of medication abortion (Grindlay & Grossman, 2017; Grindlay et al., 2013; Grossman & Grindlay, 2017; Grossman et al., 2011; Grossman et al., 2013), and should be adopted in states that require face-to-face information sessions for abortion.

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