

The Impact of a 72-hour Waiting Period on Women's Access to Abortion Care at a Hospital-Based Clinic in North Carolina

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BACKGROUND In 2015, North Carolina became the 5th state to pass legislation requiring women to undergo state-mandated counseling 72 hours prior to abortion. Whether this legislation has changed the timing of abortion decision-making or receipt of care is not known.

METHODS This is a cross-sectional study using anonymous survey data from women presenting for abortion at a hospital-based abortion clinic in North Carolina. Data were collected for 8 weeks immediately before and after implementation of the new waiting period.

RESULTS 26/48 (54%) of eligible patients participated. More than half (56%) of women made their abortion decision relatively quickly (less than or equal to 3 days), but had a median time-to-care of almost a week.

LIMITATIONS This small study is the 1st recent evaluation of abortion decision-making and receipt of care immediately before and after implementation of a 72-hour waiting period in a Southern state. Only women presenting for care at a single hospital-based clinic were surveyed. Data were self-reported.

CONCLUSION In our clinical setting, most women decided to have an abortion quickly but still waited 10-15 days before receiving care. Extended waiting periods provide no medical benefits and the potential for harm and delay of care remains.

Twenty-seven states have enacted statutes that require women to wait 24-72 hours after mandated counseling before they can have an abortion [1]. In June 2015, North Carolina increased the waiting period from 24 to 72 hours, becoming the 5th state to require women to wait 3 days prior to receiving an abortion [1, 2]. North Carolina's statute requires that women undergo counseling by phone or in person with a "qualified health professional or technician" 72 hours before an abortion, except in the setting of medical emergency. The content of this counseling is state-mandated and includes information about services that could be available to patients if they continue their pregnancies. The impact of such information on women who have abnormal pregnancies or have been raped is unknown.

There is no medical evidence that waiting periods with mandated counseling improve women's health, although there is indirect evidence of potential harm. Many women find waiting periods burdensome [3, 4]. Access to abortion to ensure women undergo the procedure at the earliest possible gestational age is important for women's health. Abortion is extremely safe, with an estimated risk of mortality that is 28 times lower than liposuction, and 10 times lower than colonoscopy [5-7]. During the first 8 weeks of pregnancy, when approximately two-thirds of abortions occur, the mortality rate is estimated to be 0.3 per 100,000 abortions [8, 9]. This rate increases almost 10-fold as gestational age increases to over 14 weeks [9]. Thus, despite the overall safety of abortion, as gestational age increases, the abortion procedure takes longer, costs more, and risks of hemorrhage and other complications increase [7, 9, 10].

At baseline, women who live in rural states like North Carolina with limited Medicaid coverage for abortion experience relatively long decision-to-abortion time [11, 12]. Because three-quarters of women having abortions are low-income, gathering resources to pay for the procedure is often a major cause of delay [10]. In North Carolina, where 90% of counties have no abortion provider and 53% of women live in those counties, long travel distances to clinics exacerbate delays in care [13]. Thus, for poor, rural women, waiting periods are only one of the many barriers faced in seeking care [14, 15, 16]. Additional barriers include arranging child care, coordinating time off work, and finding a clinic that will care for them, as women are often turned away from outpatient clinics due to obesity, prior Cesarean deliveries, or a higher than expected gestational age [11, 14, 16, 17].

The 72-hour waiting period in North Carolina went into effect on October 1, 2015. None of the recent studies on waiting periods were conducted in the South, so this paper aims to provide early data from North Carolina. We sought to describe both the timing of women's decision-making and when an individual actually underwent her procedure before and after October 1, 2015. Because most women make their decision to have an abortion prior to accessing care, we

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hypothesized that that the 72-hour waiting period would not impact the timing of women's decision-making, but could serve to delay care.

Methods

This was a cross-sectional anonymous survey of women presenting for abortion at a single clinic in North Carolina. The study was determined to be exempt by The University of North Carolina Institutional Review Board.

We conducted our study at the North Carolina Women's Hospital abortion clinic, where patients are seen for maternal medical conditions, fetal anomalies, and personal reasons. Women seen in this subspecialty clinic are racially and ethnically diverse, and many have traveled hours to receive care. Approximately 75% do not have insurance for their procedures. The clinic runs 2 days per week, and offers medication abortion, in-clinic uterine aspiration abortion, and dilation and evacuation in the operating room. Physicians also provide in-clinic counseling and obtain surgical consent. Ancillary services are provided by social workers, chaplains, and financial counselors.

When women call to schedule an appointment, they inform the clinic scheduler of their estimated gestational age. A clinic physician or nurse calls them back to perform state-mandated counseling, which includes medical, social, and personal components [2, 18]. The woman is informed of the risks associated with the procedure based on the gestational age she has self-reported. She is also informed that state financial assistance programs may be available to her both during and after pregnancy, and that the father of the baby can be held financially responsible for the baby after birth. Additionally, options to see ultrasound images or obtain additional information regarding fetal development are provided.

Our data describe the number of days from learning of pregnancy to deciding to have an abortion (time-to-decision), as well as the number of days from contacting the clinic to having an abortion (time-to-care). Data were collected using an anonymous survey administered for 8 weeks immediately before and after the law was enacted (see Figure 1). No validated tool appropriate to this setting exists, so the survey was designed by the primary investigator and piloted by the research team. Women were approached for participation if they were at least 18 years old, spoke English, and had already consented for an abortion. Eligible women received verbal and written statements describing the study. Interested participants then completed the 1-page survey in a private room and placed it in a locked box.

Sample size for this study was one of convenience, and we anticipated it would be too small to report significance levels or make statistically meaningful comparisons. Our data analysis plan was to describe timing of abortion decision-making and accessing care before and after implementation of the 72-hour waiting period using frequency reporting.

We posited that 1 week is a clinically significant amount of time to delay decision-making or access to care. Using a 95% confidence interval, we would have needed to enroll 621 women to detect a 1-week difference. A sample size this large is unobtainable in our setting, hence the descriptive nature of our study.

Results

Forty-eight women were seen in the clinic during the 16-week survey period. Twenty-six women (54%) completed the survey: 16 (62%) during the 24-hour waiting period and 10 (54%) during the 72-hour waiting period. The gestational age of women who presented was similar between both groups and most women estimated their gestational age correctly (see Table 1).

Time-to-decision (median number of days from learning of pregnancy to deciding to have an abortion), was 3 days or fewer in 67% of the 24-hour cohort and 40% of the 72-hour cohort. Time-to-care (median number of days from contacting the clinic to having an abortion) was greater than a week for over one-third of participants (see Table 1). Decision-to-abortion time was at least 1 week for more than half (54%) of the entire cohort.

Discussion

In this hospital-based clinic in North Carolina, women make their abortion decisions relatively rapidly. Time-to-care is over 1 week for almost two-fifths of women, suggesting that mandated waiting periods may extend any delay that women might already experience.

The majority of women make their abortion decisions before interacting with the health care system, whether to call for an appointment or present for care [19, 20, 21]. Often women decide at the time of, or even prior to, a positive pregnancy test [19, 20]. This was also the case in our small study. Almost one-third of women in our study reported making their abortion decision the day they found out they were pregnant, or even prior. This rapid decision-making suggests women know their pregnancy preferences well. Although counseling can be critical for women who are uncertain or need emotional support, most women do not desire additional time or counseling and have low decisional conflict [14, 19, 20, 22, 23]. Even among the 4 women who contacted the clinic prior to deciding, all had decided they definitely wanted to have an abortion by the time they were seen at their appointment.

Gestational age at the time a woman presents for an abortion is arguably the most important factor that affects her care. If a 72-hour waiting period results in a 7-day delay to receiving abortion care due to limited clinical service availability or weekends, that 1-week delay could exclude a patient from access to medication abortion, require cervical preparation prior to abortion, require a patient to travel out of state if she is pushed beyond the legal gestational age limit, increase length of procedure, and substantially

FIGURE 1.
Participant Survey

Please complete the sentences below. Attached to this survey is a blank calendar. Looking at the calendar may help you remember the answer to some of these questions and help you count the numbers of days requested.

Please let the staff know if you have any questions.

1. How long ago did you find out you were pregnant?
I found out I was pregnant ____ days ago.
2. How far along were you when you found out you were pregnant? (How many weeks pregnant?)
I thought I was ____ weeks pregnant when I found out.
Today, the doctor told me I am ____ weeks pregnant.
3. How long ago did you decide to have an abortion?
I decided to have an abortion ____ days ago.
4. Is UNC the only clinic you called about this pregnancy?
UNC (is / is not) the only clinic I called. (Please circle one)
5. If it was not - How many other clinics did you contact (or go to)?
Please skip if this doesn't apply to you
I called or went to ____ (number) of other clinics
6. How long ago did you first contact UNC to make your appointment?
I first called UNC ____ days ago to make my appointment.
7. Were you able to get an appointment as soon as you wanted?
I (was / was not) able to get my appointment as soon as I wanted. (Please circle one)
8. Why was your appointment scheduled for today? Please check all that apply:
 They told me this was the first available appointment
 This day worked best with my schedule
 They told me there's a required waiting period
 I needed to wait so I could get the money together for the procedure
 I needed to delay my appointment because I'm waiting to hear back about test results
 I needed to coordinate transportation/having someone come with me
 I wasn't really ready until today
 Other (please write in whatever best fits your situation): _____

increase costs to the woman [10, 11]. Most importantly, safety of abortion decreases as gestational age increases. Hemorrhage, the most common major complication, increases from 0-3 per 1,000 cases in the 1st trimester to 0.9-10 per 1,000 cases in the 2nd trimester [24]. Mortality rates, although exceedingly low, increase approximately 10-fold as gestational age increases from the 1st to 2nd trimester [9].

Limitations

Our descriptive study was limited by the very small sample size and inability to report statistical significance. In our limited clinical setting and rural state, we were not able to fully evaluate differences between time-to-decision or time-to-care before and after implementation of an extended waiting period. There are a number of possible limitations, aside from the small sample size. Our subspecialty hospital-based clinic provides services only 2 days per week, so even

with no waiting period, women contacting our clinic would wait, on average, 4 days for the next available appointment. Many of the women seen at the study clinic are specifically referred for hospital-based care and may not be reflective of a healthier, freestanding clinic population. Selection bias in our clinic population could have resulted in differences between the women who chose to complete the survey and those who did not. However, despite these limitations, ours is among a few recent studies to describe the effect of an extended waiting period immediately before and after implementation in a Southern state [4, 10, 14].

Although we did not see differences in our cohort, there is still cause for concern among the broader abortion-seeking population due to the potential delay in care and resultant increased risk. Within public discourse, proponents of waiting periods promote them as protecting women by ensuring sound decision-making and improving abortion safety. Opponents suggest that women do not need

TABLE 1.
Characteristics of Women Undergoing Induced Abortion when the Waiting Period was Increased from 24 Hours to 72 Hours

	24-hour group (N = 16)	72-hour group (N = 10)	Total (N = 26)
Time-to-decision (days)*			
≤ 3	10 (67%)	4 (40%)	14 (56%)
4-7	0	0	0
> 7	5 (33%)	6 (60%)	11 (44%)
Time-to-care (days)**			
≤ 3	2 (12%)	1 (10%)	3 (12%)
4-7	9 (56%)	5 (50%)	14 (54%)
> 7	5 (31%)	4 (40%)	9 (37%)
Decision-to-abortion time (days)***			
≤ 7	6 (38%)	4 (40%)	10 (38%)
> 7	10 (62%)	6 (60%)	16 (62%)
Time-to-care of at least 1 week	5 (31%)	4 (40%)	9 (35%)
Called at least 1 other abortion clinic	11 (69%)	7 (70%)	18 (69%)
Gestational age as estimated by participant (weeks)	13 [8, 19]	13 [10, 15]	12 [6, 15]
Gestational age as estimated by physician (weeks)~	13 [6, 17]	11 [6, 15]	12 [6, 17]
Called clinic prior to deciding to have an abortion	1 (6%)	3 (33%)	4 (15%)

* Time-to-decision: number of days from learning of pregnancy to decision to have an abortion;

N = 15 in the 24-hour group (one participant did not respond to this question).

** Time-to-care: number of days between first clinic contact and abortion procedure.

*** Decision-to-abortion time: number of days from deciding to have an abortion to abortion

protection from their own autonomous capacity for decision-making and should have prompt access to what is already a very safe procedure. There are limited data to suggest that a minority of women with decisional uncertainty may change their minds during a mandated waiting period [15]. However, the question remains whether this outweighs the harm of undermining the decision-making of the majority of women with no decisional uncertainty or of decreasing the safety of abortion for women who do undergo the procedure by delaying care and thereby increasing gestational age.

Conclusion

Restrictive laws that close clinics or impose waiting periods result in increases in gestational age at time of abortion and unintended birth rates among high-risk populations [25, 26]. We recommend further study to investigate the impact of abortion wait times on access to care, especially for rural and economically disadvantaged women. Researchers should explore the potential medical, social, and ethical costs of mandated counseling and waiting periods, as well as their impact on patient autonomy and the patient-provider relationship. Like many other states, North Carolina has additional abortion restrictions (eg, gestational age limits, submission of ultrasound images, clinic facility regulations) that may make it challenging to separate the harms or benefits of a specific restriction. However, well-conducted research could provide policymakers the data from which to ensure that any future legislation is based on evidence regarding true medical and social benefits. **NCMJ**

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