ORIGINAL RESEARCH

Primary Care Clinicians' Interest In, and Barriers To, Medication Abortion

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Purpose: **Providing medication abortion in the primary care setting is a promising way to increase access to abortion, a threatened service in many States. This study aimed to characterize primary care clinicians' interest in prescribing medication abortion, what barriers they face in adding this service, and what support they need.**

Methods: **Data were collected from 162 practicing primary care clinicians in Minnesota using an online survey with closed- and open-ended response options. Data were analyzed using descriptive statistics, group comparison analyses, and content analysis for the open-ended questions.**

Results: **Participants represented a diverse range of ages, years in practice, credentials, genders, and urban/rural practice settings, and held mixed knowledge and attitudes around medication abortion. All demographic groups surveyed expressed interest in prescribing medication abortion, with the strongest interest represented among younger respondents, women, and those practicing in urban settings. Clinicians who provide prenatal care or who already work with these medications in other contexts were more likely to want to add medication abortion to their practices. The most common barrier to providing medication abortion was a lack of knowledge about organizational policies and about the medications themselves. To empower clinicians to provide medication abortion, respondents voiced needing their health systems to build clear processes and wanting supportive networks of other clinicians for collaboration.**

Conclusions: **Given the interest of primary care clinicians in providing medication abortion, health systems have a valuable opportunity to increase access. (J Am Board Fam Med 2024;37:680–689.)**

Keywords: **Abortion-Induced, Access to Care, Contraceptive Agents, Family Medicine, Family Planning Services, Mifepristone, Minnesota, Misoprostol, Primary Health Care, Scope of Practice, Surveys and Questionnaires, Unplanned Pregnancy**

Introduction

In the rapidly changing legal climate following the overturning of *Roe v. Wade*, the medical community is working to meet patients' needs for accessible legal abortion.[1] States where abortion remains legal have seen increased demand from patients traveling to seek this essential health care.[2] Medication abortion is a promising safe, effective, and efficient tool to meet this demand, in part given that it can be provided in primary care settings by a variety of licensed medical providers.[3,4] Many primary care practices have already played an important role in increasing access to medication abortion by instituting telemedicine abortion in a rapid response to the COVID-19 pandemic.[5,6] Increasing medication abortion provision in the primary care setting would also improve geographic access: abortion rates are lower in counties farther from abortion clinics, and mathematical modeling shows that this discrepancy could decrease if primary care providers offered abortion care.[7]

However, primary care clinicians face multifaceted barriers to providing medication abortion, with legal barriers a commonly cited roadblock.[8] Other studies suggest that administrative roadblocks such as writing patient education and consent forms or building clinic workflows prevent primary care clinicians from providing this service.[5,9–12] Although these barriers are well characterized, less research exists on whether primary care clinicians are interested in incorporating medication abortion into their

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practices and on what resources they would want to support them in adding this service.[8] In addition, existing studies on interest in and barriers to providing medication abortion often do not explore demographic differences in these metrics.

In 2022, a Minnesota court struck down many legal barriers to abortion,[13] providing the opportunity for the expansion of medication abortion into the primary care setting in the state. This study surveyed primary care clinicians across Minnesota to investigate what demographic trends exist in interest in adding medication abortion to their practices, what barriers stand in their way, and what resources they want to support them in expanding access.

Methods

We conducted a cross-sectional online survey with closed- and open-ended response options to measure interest in and barriers to providing medication abortion. All study protocols were approved by the University of Minnesota Institutional Review Board.

Recruitment

Recruitment messages described the study as researching "clinician interest in—and barriers to—providing medication abortion" and contained a link to an online survey. These messages were e-mailed to primary care clinician-specific listservs, including the Minnesota Academy of Family Physicians, the Minnesota affiliate of the American College of Nurse-Midwives, and the Minnesota cluster of the Reproductive Health Access Project. These listservs were chosen as they include the professional organizations of the range of licensed clinicians who are legally allowed to provide medication abortion in Minnesota. Minnesota-specific listservs were chosen because the state's increasingly favorable legal climate for abortion access, in contrast to its more restrictive neighbors, positions the state as a promising target to meet unmet patient need. Participants were not compensated for completing the survey but were able to opt-in to receive educational resources (eg, "provider guide" information sheets) to support them in providing medication abortion.

Survey Process

The survey was delivered via a web-based form in English. The survey was designed to take about 5 minutes to submit, but participants could complete it in multiple sittings if they left their web browser open. If participants chose to provide their contact information (eg, to receive resources or ask questions), these responses were anonymized and stored separately from their contact information.

Survey Tool

The initial drafts of the survey were informed by feedback from 3 physicians in different primary care specialties who provide abortion care.

The demographic information collected in this survey included credentials, specialty, age, years in practice, gender identity, and primary work site location by county. County responses were categorized by urban/town/rural status.[14] Participants were asked whether they had provided miscarriage management care or prenatal care within the last year, whether they currently prescribe mifepristone and/or misoprostol for other types of care besides abortion (eg, early pregnancy loss), and whether they currently provide medication abortion.

To assess knowledge and attitudes around medication abortion, all participants were provided the definition, "Medication abortion refers to the use of medications, most commonly mifepristone and misoprostol, to end a viable pregnancy," then asked to rate their support and their confidence in their knowledge. A modified 7-point Sexual Health Education Professionals Scale (SHEPS) was used, as it has been validated to assess sexual health knowledge and attitudes in health care professionals.[15] Lower numbers on this scale represent more knowledge and more support of medication abortion.

Participants who do not currently offer medication abortion (n = 149) were further asked if they were interested in providing this service in their practice. All respondents who selected "Yes" or "I need more information to decide" (81 respondents minus 4 incomplete responses, per data cleaning protocol as described below: n = 77) were asked about what barriers stop them from providing this care. Answer choices included those listed in Table 5, as well as a write-in "Other" option. These participants were also asked what information or resources they need to support them in adding medication abortion to their practice.

Analysis

Quantitative data were analyzed using SPSS 28.0 using descriptive statistics and bivariate analyses such as *t* test (for comparing a continuous variable

across 2 categories), ANOVA (for comparing a continuous variable across 3 or more categories), and Chi square (for comparing 2 categorical variables). Level of significance was set at $P < .05$. Qualitative data were analyzed using content analysis guided by Hsieh and Shannon.[16]

Results

Data Cleaning

The survey received 171 responses. Data were inspected for completeness and eligibility and 9 responses were removed from analysis, leaving 162 valid responses. Of the 9 responses removed, 2 respondents did not practice in Minnesota, 1 respondent was retired, and 6 did not finish the survey. Four additional respondents did not answer the last section about barriers to prescribing; these 4 responses were excluded from the barrier analysis but included in the remaining analyses.

Cisgender and transgender participants were grouped for analysis in accordance with their gender identities (eg, cisgender and transgender men were both included in the man/male/masculine category). As only 1 respondent was a transgender man and 1 was a transgender woman, this grouping maintained their anonymity while enabling their inclusion in the analysis.[17]

Participant Characteristics

As the largest recruitment network used was the Minnesota Academy of Family Physicians' listserv, 82.1% of respondents identified their specialty as family medicine, and 87% were MD/DOs. Demographic characteristics of the participants are provided in Table 1.

Although a majority of respondents did not currently provide abortion care, a narrow majority reported that they practice other pregnancy-related care such as prenatal care, miscarriage management care, and/or early pregnancy loss care (Table 2). Participants disclosed a wide range of confidence levels in their knowledge to care for patients seeking medication abortion, with the median answering 3, "slightly confident."

Demographic Distribution of Knowledge and Attitudes toward Medication Abortion

Participants' confidence in their knowledge of medication abortion did not follow many predictable demographic trends: age, time in practice, county type, and gender were not significantly associated with knowledge (Table 3). However, both county type and gender were significantly associated with support for medication abortion. On a 7-point scale where 1 is very supportive, 4 is neither supportive nor unsupportive, and 7 is very unsupportive, clinicians practicing in urban areas were significantly more supportive (Mean 1.89 (Standard Deviation, 1.95)) than those practicing in urban/town/rural mixed areas (3.03 (2.75)) or in entirely rural and town/rural mixed areas (2.81 (2.46), $F(2)=4.04$, $P<.05$). Women/female/feminine respondents were significantly more supportive (M 1.89 (S.D. 1.97)) than man/male/masculine respondents (2.85 (2.51)) and nonbinary respondents (3.50 (3.54), $F(3) = 5.77$, $P < .001$).

Clinicians' participation in other pregnancy-related care was also associated with their knowledge—but not their support—of medication abortion. Clinicians who prescribe mifepristone and/or misoprostol in contexts other than abortion were more confident in their knowledge of medication abortion (M 2.56 (S.D. 1.62)) than their colleagues

Table 1. Participant Demographics* (n = 162)

Characteristic	M (S.D.)† or n (%)
Age	47.43 (11.43)
Years in practice	17.05 (11.43)
Gender identity	
Man, male, masculine	40 (24.7%)
Woman, female, feminine	118 (72.8%)
Gender nonbinary, gender nonconforming	2 (1.2%)
Credentials	
DO or MD	141 (87%)
CNM, NP, PA, MPH	21 (13%)
Primary care specialty	
Family medicine	135 (82.3%)
Non-family medicine	27 (16.7%)
Practice setting county classification	
Entirely urban	110 (67.9%)
Urban/town/rural mix	29 (17.9%)
Entirely rural or town/rural mix	21 (13%)

*Participants are Minnesota primary care clinicians with the legal ability to prescribe medication abortion who participated in an online survey about interest in and barriers to prescribing medication abortion in 2023.
†M (S.D.) represents Mean (Standard Deviation).
Abbreviations: DO, doctor of osteopathic medicine studies; MD, doctor of medicine; NP, nurse practitioner; PA, physician assistant; CNM, certified nurse midwives; MPH, master of public health.

Table 2. Minnesota Primary Care Clinicians'* Experience with Abortion-Related Care (n = 162)

Question	Response Options	n (%)
Do you currently provide medication abortion in your practice?	Yes	13 (8%)
	I don't, but others in my practice do	20 (12.3%)
	No	126 (77.8%)
	I'm not sure	3 (1.9%)
Have you provided any prenatal care within the last year?	Yes	92 (56.8%)
	No	70 (43.2%)
Have you provided any miscarriage management care within the last year?	Yes	85 (52.5%)
	No	77 (47.5%)
Do you currently prescribe mifepristone and/or misoprostol in your practice for other types of care besides abortion (e.g., early pregnancy loss)?	Yes	62 (38.3%)
	I don't, but others in my practice do	28 (17.3%)
	No	71 (43.8%)
	I'm not sure	1 (0.6%)
Do you feel confident that you have the knowledge to care for patients seeking medication abortion?	1 Very confident	30 (18.5%)
	2 Moderately confident	48 (29.6%)
	3 Slightly confident	21 (13%)
	4 Neither confident nor unconfident	17 (10.5%)
	5 Slightly unconfident	11 (6.8%)
	6 Moderately unconfident	16 (9.9%)
	7 Very unconfident	19 (11.7%)
	0 Don't know	0 (0%)
To what extent do you support the use of medication abortion as an abortion method when indicated?	1 Very supportive	112 (69.1%)
	2 Moderately supportive	14 (8.6%)
	3 Slightly supportive	6 (3.7%)
	4 Neither supportive nor unsupportive	2 (1.2%)
	5 Slightly unsupportive	0 (0%)
	6 Moderately unsupportive	6 (3.7%)
	7 Very unsupportive	20 (12.3%)
	0 Don't know	2 (1.2%)

Data shown are from an online survey about interest in and barriers to prescribing medication abortion conducted in 2023.
*Clinicians: those with the legal ability to prescribe medication abortion in Minnesota (MD, DO, CNM, PA, NP).
Abbreviations: DO, doctor of osteopathic medicine studies; MD, doctor of medicine; NP, nurse practitioner; PA, physician assistant; CNM, certified nurse midwives.

who do not prescribe these medications (4.15 (2.14), $F(2) = 12.07$, $P < .001$). Similarly, clinicians who provide prenatal care were more confident in their knowledge (2.71 (1.65)) compared with those who do not provide prenatal care (4.17 (2.17), $F(160) = 15.80$, $P < .001$); and those who provide miscarriage management care were more confident (2.95 (1.85)) than those who do not (3.77 (2.13), $F(160) = 5.83$, $P < .01$). None of these groups were significantly more supportive of medication abortion than their colleagues who do not provide these services.

Whether or not a clinician already provides medication abortion, or has colleagues who do, was also associated with their knowledge and support of medication abortion (Table 3); however, small eta-squared (η^2) values for knowledge (η^2=0.08) and support (η^2=0.05) indicate that whether or not a clinician already prescribes medication abortion does not account for the majority of the variance seen in the sample.[18]

Interest in Providing Medication Abortion

Age, time in practice, gender, and urban/rural practice setting were all significantly associated with interest in providing medication abortion (Table 4). The participants who were interested in providing abortion care were younger (mean age 44.00 (standard deviation 10.23)) as compared with those not interested in providing abortion care (49.63 (11.85), $F(2) = 4.45$, $P < .05$). Interested participants had spent fewer years in

Table 3. Minnesota Primary Care Clinicians'[†] Knowledge and Attitudes Toward Medication Abortion (n = 162)

Variable	Knowledge of medication abortion[‡]	Attitudes toward medication abortion[§]
Age	Correlation = 0.04	Correlation = −0.01
Years in practice	Correlation = 0.07	Correlation = 0.03
Gender identity		
Man, male, masculine	3.83 (2.23)	2.85*** (2.51)
Woman, female, feminine	3.19 (1.95)	1.89*** (1.97)
Gender nonbinary, gender nonconforming	2.50 (2.12)	3.50*** (3.54)
Practice setting county classification		
Entirely urban	3.35 (2.01)	1.89* (1.95)
Urban/town/rural mix	3.55 (2.25)	3.03* (2.75)
Entirely rural or town/rural mix	2.86 (1.68)	2.81* (2.46)
Have you provided any prenatal care within the last year?		
Yes	2.71*** (1.65)	2.18 (2.22)
No	4.17*** (2.17)	2.24 (2.21)
Have you provided any miscarriage management care within the last year?		
Yes	2.95* (1.85)	2.15 (2.16)
No	3.77* (2.13)	2.27 (2.28)
Do you currently prescribe mifepristone and/or misoprostol in your practice for other types of care besides abortion (e.g., early pregnancy loss)?		
Yes	2.56*** (1.62)	1.92 (1.96)
I don't, but others in my practice do	3.04*** (1.80)	2.25 (2.24)
No	4.15*** (2.14)	2.46 (2.41)
Do you currently provide medication abortion in your practice?		
Yes	1.92** (1.32)	1.08* (0.28)
I don't, but others in my practice do	2.80** (1.54)	1.40* (0.88)
No	3.52** (2.07)	2.48* (2.42)

Data shown are from an online survey about interest in and barriers to prescribing medication abortion conducted in 2023.
[†]Clinicians: those with the legal ability to prescribe medication abortion in Minnesota (MD, DO, CNM, PA, NP).
[‡]Seven-point scale where 1 is very confident in knowledge, 4 is neither confident nor unconfident in knowledge, and 7 is very unconfident in knowledge. Reported as Mean (Standard Deviation).
[§]Seven-point scale where 1 is very supportive, 4 is neither supportive nor unsupportive, and 7 is very unsupportive. Reported as Mean (Standard Deviation).
*, $P < .05$; **, $P < .01$; ***, $P < .001$ using a one-way ANOVA (for variables with three categories) or a two-sided t test (for variables with two categories).
Abbreviations: DO, doctor of osteopathic medicine studies; MD, doctor of medicine; NP, nurse practitioner; PA, physician assistant; CNM, certified nurse midwives.

practice (mean, 12.86 years (standard deviation 9.64)) than those not interested (20.04 (11.79), $F(2) = 7.26$, $P < .001$). More women/female/feminine respondents were interested (49.5%) as compared with men/male/masculine respondents (17.9%, $\chi^2(6) = 15.68$, $P < .05$), and clinicians in urban counties were more likely (53.0%) than those in other practice settings (urban/town/rural mix (11.1%) and entirely rural or town/rural mix (19.0%), $\chi^2(4) = 21.09$, $P < .001$) to want to add medication abortion to their practices.

Having experience in related areas was also associated with interest (Figure 1). Clinicians who provide prenatal care were more than twice as likely (53%) to be interested in adding medication abortion to their practices compared with those who do not provide prenatal care (26%, $\chi^2(2) = 11.72$, $P < .01$). Clinicians who currently prescribe mifepristone and/or misoprostol for types of care other than abortion were 1.51 times more likely (53%) to be interested in adding medication abortion to their practice compared with those who do not

Table 4. Interest in Providing Medication Abortion among Minnesota Primary Care Clinicians[†] Who Do Not Already Provide This Care (n = 149)

	Interest in Providing Medication Abortion		
	Mean (Standard Deviation) or n (%)		
Variable	Yes (n = 60)	No (n = 68)	I need more information to decide (n = 21)
Age	44.00* (10.23)	49.63* (11.85)	49.55* (12.00)
Years in practice	12.86*** (9.64)	20.04*** (11.79)	19.36*** (12.32)
Gender identity			
Man, male, masculine	7 (17.9%)*	25 (64.1%)*	7 (17.9%)*
Woman, female, feminine	53 (49.5%)*	40 (37.4%)*	14 (13.1%)*
Gender nonbinary, gender nonconforming	0 (0%)*	1 (100%)*	0 (0%)*
Practice setting county classification			
Entirely urban	53 (53.0%)***	35 (35.0%)***	12 (12.0%)***
Urban/town/rural mix	3 (11.1%)***	20 (74.1%)***	4 (14.8%)***
Entirely rural or town/rural mix	4 (19.0%)***	13 (61.9%)***	4 (19.0%)***
Have you provided any miscarriage management care within the last year?			
Yes	37 (48.1%)	30 (39.0%)	10 (13.0%)
No	23 (31.9%)	38 (52.8%)	11 (15.3%)
Do you feel confident that you have the knowledge to care for patients seeking medication abortion?[‡]	2.85** (1.70)	3.69** (2.15)	4.48** (2.04)
To what extent do you support the use of medication abortion as an abortion method when indicated?[§]	1.05*** (0.29)	3.72*** (2.73)	1.33*** (0.80)

Data shown are from an online survey about interest in and barriers to prescribing medication abortion conducted in 2023.
[†]Clinicians: those with the legal ability to prescribe medication abortion in Minnesota (MD, DO, CNM, PA, NP).
[‡]Seven-point scale where 1 is very confident in knowledge, 4 is neither confident nor unconfident in knowledge, and 7 is very unconfident in knowledge. Reported as Mean (Standard Deviation).
[§]Seven-point scale where 1 is very supportive, 4 is neither supportive nor unsupportive, and 7 is very unsupportive. Reported as Mean (Standard Deviation).
*, $P < .05$; **, $P < .01$; ***, $P < .001$ using a one-way ANOVA (for continuous variables) or a χ^2 test (for categorical variables).
Abbreviations: DO, doctor of osteopathic medicine studies; MD, doctor of medicine; NP, nurse practitioner; PA, physician assistant; CNM, certified nurse midwives.

work with these medications (36%, $\chi^2(4) = 12.45$, $P < .05$).

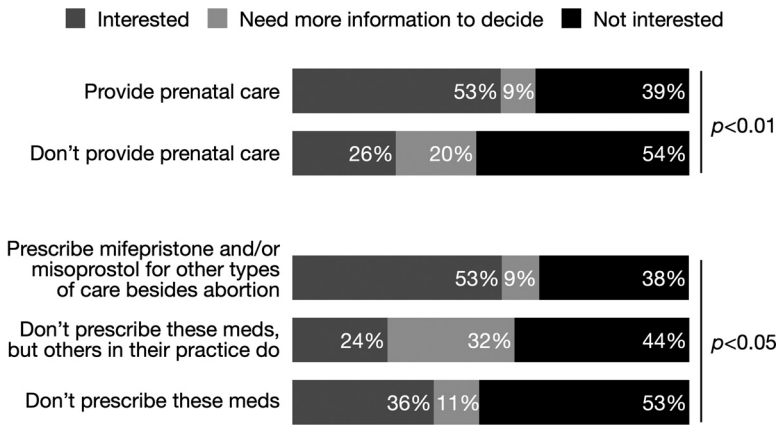
Barriers to Providing Medication Abortion: Processes

Clinicians identified many policy-related or procedural barriers to providing medication abortion (Table 5). For example, over one-third of the sample of clinicians who indicated interest in providing medication abortion selected that they "do not know [their] employer/health system's policy," 28.6% were concerned about their ability to manage or refer patients if complications arose, and 22.1% were not sure how to or could not access the medications.

In their free-text responses, respondents elaborated on the lack of processes to support medication abortion care. Many participants (38.9%) described the need for their organizations to provide workflows, educational materials, and follow-up plans. One participant summarized, "clinics and health systems often do not have protocols and policies created to implement medication abortion provision and this can often serve as a barrier because it simply takes time and resources to implement something new." Multiple respondents voiced frustrations over the pace of these changes; for example saying, "everything in health care is a slow-moving ship, and full of policies, procedures and endless e-mails."

Participants also shared concerns about how providing medication abortion would fit into their practices. Clinicians voiced fears that their schedules would become dominated by this type of care; for example saying, "I also do not want to provide

Figure 1. Interest in providing medication abortion among Minnesota primary care clinicians who do not already provide this care, according to clinicians' current practice offerings (n = 149). Numbers reported as percentages; *P* values reported are from χ^2 tests.



abortion services to the entire system, just my group of patients." Similarly, the proper scope and place of this care was frequently mentioned. A few respondents expressed doubt over whether their field is an appropriate place for this care, for example, writing, "I am not sure if that qualifies under OB care and I am strictly family medicine with no OB privileges in this current job position." However, others voiced enthusiasm for prescribing medication abortion in primary care. One participant elaborated, "hospitals and clinics were happy to turn most abortion care over to freestanding clinics - it took the heat off them. Now they need to step up to the plate and resume providing this critical piece of reproductive health care."

Table 5. Barriers to Providing Medication Abortion Among Minnesota Clinicians† Interested in Adding This Service to Their Practice (n = 77)

Barrier	n (%) Who Endorsed the barrier
I don't know my employer/ health system's policy	28 (36.4%)
I don't know enough about the medications to prescribe them	27 (35.1%)
I am worried about my ability to safely managing or refer for complications	22 (28.6%)
I don't know enough about the medications to educate patients about them	19 (24.7%)
I don't know how to or can't get access to the medications	17 (22.1%)
My employer/ health system has a policy against it	11 (14.3%)
My colleagues and/or staff are not supportive	7 (9.1%)

Data shown are from an online survey about interest in and barriers to prescribing medication abortion conducted in 2023.
†Clinicians: those with the legal ability to prescribe medication abortion in Minnesota (MD, DO, CNM, PA, NP).
Abbreviations: DO, doctor of osteopathic medicine studies; MD, doctor of medicine; NP, nurse practitioner; PA, physician assistant; CNM, certified nurse midwives.

Barriers to Providing Medication Abortion: Knowledge and Support

Participants' lack of knowledge about the medications was also a common barrier to providing medication abortion services: 35.1% of clinicians interested in prescribing medication selected that they "do not know enough about the medications to prescribe them," and 24.7% selected that they "do not know enough about the medications to educate patients about them" (Table 5).

Notably, only 9% of respondents identified a lack of support from their colleagues or staff as a barrier. However, those who did shared that these fears have far-reaching consequences. One clinician's experience of blowback after a recent use of these medications made them realize, "I will likely never feel safe or supported doing elective AB work in my current practice (even though I have been trained to do so)." Clinicians shared fears of personal consequences as well, sharing they feel "worried about the personal implications of providing this service in a small rural community due to lack of anonymity."

Resources Clinicians Want

When asked about what resources clinicians wanted to support them in adding medication abortion to their practices, three main themes were identified in the data: training and education, networking, and infrastructure.

First, clinicians shared that they want training and education. Specifically, a few respondents noted they would want assistance finding preceptors and/or experienced clinicians to shadow. Others noted that it would be important to build training time into their schedule, "ideally paid or with CME" credit available.

Second, clinicians voiced a need for networks to connect with others providing this care. One wrote, "It would be great to have a group of APRNs who are working to implement abortion care who come together across health systems and clinics to help support and guide and offer resources to folks." Another clinician further emphasized the need for this community, sharing that "no one else that I know in the area is doing it." Expanding on this idea, another respondent shared that better communication between clinicians would also be important for consistency. They wrote, "This is not an issue only around abortion care but our systems need to talk to each other. It is ludicrous that my colleges [*sic*] 2 miles away are providing medication abortions while in my service we are continually bogged down by paperwork, lack of access to unnecessary ultrasounds, etc. I really wish that we could have a unified front, state-wide."

And third, respondents shared that they need their employers to build processes and buy in to providing this care. Similar to the above responses about logistic barriers, many clinicians shared the need for "workflow in clinic," "order set with handouts for patients," "how my system will fill mifepristone," "referral support," "plan for follow-up," and more.

Discussion

This study aimed to characterize clinicians' perspectives on adding medication abortion to their practices, and to describe how practice setting and clinician characteristics influence interest in providing this care. Across all demographics surveyed, clinicians voiced interest in adding this service. This demographic information has not been reported in other studies that detail clinician interest in implementing medication abortion, and is important because it demonstrates interest in populations sometimes perceived as less favorable toward abortion (such as clinicians practicing in rural settings).[8] One population we identified that had overwhelming interest was clinicians who already have familiarity with this field, through working with the medications in different contexts or providing other pregnancy-related care. Interestingly, this population was not significantly more supportive of medication abortion. Instead, it is possible that their greater knowledge of the medications and fewer policy-related barriers to providing this care could explain their increased interest. This is consistent with a Canadian study that characterized a major barrier to Nurse Practitioners adding medication abortion to their practices as "navigating the huge bureaucratic process of organizational implementation."[11] Given that clinicians with experience in other types of pregnancy-related care are interested, knowledgeable, and able to provide medication abortion, targeting them as early implementers of this service in primary care is promising.

The barriers and concerns clinicians shared about providing this care are helpful and relevant to health system administrators looking to add medication abortion to the services they offer. Many of the barriers identified are the responsibility of employers and health systems to solve; for example, adding training opportunities, planning clinic workflows, and supporting follow-up protocols. In research about implementation of new health care services, building care processes like these has been described is a major component of successful service adoption.[19]

A second important factor that implementation science literature describes is the health system's capacity to change,[19] which is often dependent on a "clinic champion" or advocate.[20] Clinic champions have been shown to be instrumental for implementation of medical abortion.[5] Some of the barriers identified in this study are particularly well suited to being addressed by clinician champions, such as increasing their knowledge about the medications, finding networks of providers for referral support, and community building between clinicians. As respondents voiced frustration with the slow speed of policy change, these findings are a practical way for clinicians to take action themselves, especially since the social stigma and legal precarity surrounding abortion makes implementation particularly difficult.[5] Existing learning collaboratives, such as the Reproductive Health Access Project[21] and the ExPAND Mifepristone Learning Collaborative[22] can also assist clinicians and health systems in overcoming these barriers. Information about these

collaboratives was sent to participants who indicated they wanted to receive further resources.

The barriers we describe above have been recently characterized in other studies[8,12] and shown to be important to address to enable successful implementation.[5] One unique barrier we describe that has not been as well characterized in the literature was clinicians' concerns about how medication abortion would fit into the scope of their primary care practices. Participants' comments on this topic were particularly rich, ranging from worries that their schedules would be dominated by this care to feelings of responsibility to increase access. Past research has outlined medication abortion as within the scope of primary care, and suggested that this service is particularly well suited to family practice providers' strengths in relationship building and counseling.[3] In addition, interviews with family physicians have identified that abortion care is closely aligned with their specialty's values including nonjudgmental care and serving the needs of community.[23] Education and outreach to primary care clinicians should include conversations around scope and space. To be particularly effective, this outreach could highlight how providing medication abortion uses primary care clinicians' proven strengths and values.

One limitation of this study stems from its recruitment. Since the Minnesota Academy of Family Physicians listserv was the largest recruitment network used, a majority of survey respondents were family physicians. The other recruitment avenues were less well publicized, meaning fewer respondents were Advanced Practice Clinicians and/or were in fields other than family medicine. Therefore, we were unable to draw any conclusions about differences between credential groups or specialties.

In summary, we found that primary care clinicians across ages, genders, and geographical settings are interested in adding medication abortion to their practices. Clinicians who provide other pregnancy-related care represent a promising group of early implementers of this service due to their confidence in their knowledge of medication abortion, and the relative lack of policy-related and procedural barriers in their practices. Conversely, clinicians in other fields identified many procedural and knowledge-based barriers to implementation. To support them in adding medication abortion to their practices, clinicians shared that they want support with training and education, connections with others providing this care, and employer buy-in and structural support. In a post-*Roe* world, where states with legal abortion must rise to meet the needs of their neighbors, primary care clinicians can help increase access by adding medication abortion to their practices.

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