Author’s response to reviews

Title: Spatial dimensions of telemedicine and abortion access: a qualitative study of women’s experiences

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Author’s response to reviews:

We thank the reviewers for their useful suggestions. We have addressed them point by point below.

Reviewer reports:

Reviewer #1: Very interesting and useful analysis of the benefits of telemedicine based on spacial dimensions.

When you discuss the anti-choice women saying that abortion should not be easy for other women, it is important to say that anti-choice women commonly present to abortion clinics.


Thank you for this suggestion. We have added this point into the discussion section.

Reviewer #2: I found this paper to be interesting, and of value in that it focuses on voices of abortion patients, who are often overlooked or stereotyped. While I did not find some of the findings particularly revolutionary - that a 72 hour waiting period law imposes undue burdens and allowing the first visit to occur by telemedicine reduced this burden - I did find the following information of particular interest:

- The 72 hour waiting period translated into a median wait of 8 days;
- The stigma experienced by some women was internalized so deeply that even though they bore the burden of these unjust laws, they still felt that it was necessary for 'other, reckless' women.

Some suggestions that could make the paper stronger:

- Consider rephrasing 'mandated disclosure visits' as 'mandatory counseling visits' - the former is not a term I see used widely.

We have rephrased “mandated disclosure visits” to “information visits” based on how this appointment is referred in other literature (e.g. Sanders JN, Conway H, Jacobson J, Torres L, Turok DK. The Longest Wait: Examining the Impact of Utah’s 72-Hour Waiting Period for Abortion. Women’s Heal Issues. 2016 Sep 1;26(5):483–7.). We avoid the term “counseling” because we did not want to imply that the visit involved a counseling visit tailored to the women, e.g. dialogue, when in fact all that occurs is that patients are read a mandated script.

- Place the 72 hour waiting period law into context - Utah has numerous anti-abortion laws, including funding restrictions, parental consent, and unnecessary clinic regulations that all contribute to a hostile climate that makes abortion extremely stigmatized.

We have incorporated this point into the background section.

- There is a growing body of research on direct to patient telemedicine that would be worthwhile to acknowledge (see the Hyland et al article on the Tabbot Foundation's service in the Aust N Z J Obstet Gynaecol (2018) or any of the Women on Web articles. Gynuity Health Projects is operating the TelAbortion project in the U.S. where the abortion pills are mailed to patients after a video consult. While eliminating one in-person visit makes a big difference, patients still need to travel sometimes great distances for the other in-person visit. If the entire service could be provided by telemedicine it would be much more convenient for patients.

We have incorporated this point into the conclusion in reflection of the evidence presented in the introduction on telemedicine for medication abortion provision in the US. Because there are a growing number of telemedicine models used for medication abortion provision, we have presented evidence that aligns with the model used to provide the information visits explored in this paper (i.e. synchronous model with video), and have focused on evidence specific to patient-provider acceptability and interaction.
The abstract - 'we explored women's experiences of using telemedicine for the first step' - gave me the expectation of hearing details of how women found it to communicate via video, whether it strained the doctor-patient relationship, how providers navigated the challenge of having to disclose mandated information that was factually incorrect. Did patients mostly do the video consult at home, or elsewhere? If any of these details could be included it would be very interesting.

About one-third of the sample lived relatively close to the clinic (within 50 miles). Did this group differ in their motivation for using telemedicine, or their experience in accessing care?

We agree these are important areas; they are explored in full in a separate manuscript as they require more space than we had here. We have now cited the additional work in the methods section for the interested reader.

In the Methods section, how many patients completed the online survey? Was there a sampling scheme used to select who was recruited? The authors note that participants were a 'diverse group of women' - was that by design?

We have updated the sampling information in the methods section to provide clarity on our sample size. It was not by design that participants were a diverse group of participants, and we have removed this sentence from this section because it does not belong in the methods.

The section on religious influences (332-393) could be shortened. What could be expanded upon is something alluded to in the Discussion - how low-income patients were disproportionately affected by the 72 hour waiting period.

We have added a sentence to the discussion in regard to the implications for our economically disadvantaged participants.

There is no mention of study limitations in the Discussion.

We have now added a discussion of study limitations.