Slow implementation of mifepristone medical termination of pregnancy in Quebec, Canada: a qualitative investigation

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Slow implementation of mifepristone medical termination of pregnancy in Quebec, Canada: a qualitative investigation

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ABSTRACT

Objectives: Mifepristone for first-trimester medical termination of pregnancy (MTOP) became available in Quebec in 2018, one year after the rest of Canada. Using the theory of the Diffusion of Innovation (DOI) and the transtheoretical model of change (TTM), we investigated factors influencing the implementation of mifepristone MTOP in Quebec.

Material and Methods: Semi-structured interviews were conducted with 37 Quebec physicians in early 2018. Deductive thematic analysis guided by the theory of DOI explored facilitators and barriers to physicians’ adoption of mifepristone MTOP. We then classified participants into five stages of mifepristone adoption based on the DOI. Follow-up data collection one year later assessed further adoption.

Results: At baseline, three physicians provided mifepristone MTOP (Maintenance) and two were about to start (Action). Thirteen physicians at Preparation and Advanced Contemplation stages intended to start while, within the Slow Contemplation, two intended to start and ten were unsure. Seven had no intention to provide mifepristone MTOP (Pre-Contemplation). Major reported barriers were: complexity of local health care organisations, medical policy restrictions, lack of support, and general uncertainty. One year later, ten physicians provided mifepristone MTOP (including three at baseline) and nine still intended to, while seventeen did not intend to start provision. Seven of sixteen participants (44%) who worked in TOP clinics at baseline were still not providing MTOP with mifepristone one year later.

Conclusion: Despite ideological support, mifepristone MTOP uptake in Quebec is slow and laborious, mainly due to restrictive medical policies, vested interests in surgical provision and administrative inertia.

Abbreviations: CART: Canadian Abortion Research Team; CART-Mife-Study: CART-Mifepristone Abortion Medical Termination Study; CMQ: College of physicians of Quebec; DOI: Diffusion of innovation; FP: Family physician; MIFE-MISO: Mifepristone-misoprostol combination; MTOP: Medical termination of pregnancy; OB: Obstetrician-gynaecologist; T1 MTOP: First trimester medical termination of pregnancy; TOP: Termination of pregnancy; TTM: Transtheoretical model of change

Introduction

In 2012, there were nearly 101,000 voluntary terminations of pregnancy (TOP) reported in Canada, for a termination rate of 14.1/1000 women aged 15–44 years [1,2]. At that time, most TOP were surgical (96%) [3], and medical terminations of pregnancy (MTOP) were still performed using methotrexate/misoprostol or misoprostol alone [4]. British Columbia and Quebec were the only provinces where TOP services were equally located in urban and rural areas [3]. Owing to a long history of feminists’ battles, favourable policies and governmental support [5], Quebec has 49 public TOP facilities, representing half of all facilities found in Canada in 2012 [3]; TOP stigma and harassment is almost nonexistent [3]. In July 2015 [6], more than 25 years after France and China [4], Health Canada approved the mifepristone-misoprostol combination (MIFE-MISO) for first trimester MTOP (T1 MTOP). It was believed that MIFE-MISO would increase access to TOP care for all Canadian women and offer them a new early TOP option. However, while medication approval falls under federal jurisdiction, provinces are responsible for the delivery of health care and may impose their own restrictions. As seen in Table 1, Health Canada’s initial approval was associated with several restrictions [7], two of which were in contradiction with existing policies in Quebec. Following availability of MIFE-MISO in Canada in January 2017 [8], Health Canada removed most of its restrictions, including mandatory online TOP
The training programme required for certification by Health Canada was provided by the Society of Obstetricians and Gynaecologists of Canada. In December 2017, the College of physicians of Quebec (CMQ), the regulatory body for medical practice in Quebec, released its own guidelines, authorising availability of MIFE-MISO in Quebec (one year later than the rest of Canada), with its own restrictions, including mandatory TOP clinical training for physicians not already providing TOP or curettage [11].

Adoption of a new behaviour such as a new clinical practice is often variable amongst individuals. As shown by Prochaska and DiClemente with the transtheoretical model of change (TTM) [12], people move through a series of stages when modifying behaviour: Pre-Contemplation, Contemplation, Preparation, Action and Maintenance. A sixth stage may be added for Relapse [12]. The TTM recognises change as a process that develops over time. In parallel, Rogers’ theory of the Diffusion of Innovation (DOI) [13,14] defines the adoption of innovation amongst individuals within a social system on the basis of their innovativeness, or in other words, on their rate of adoption of an innovation, also divided into five categories comparable to those of TTM. The theory of the DOI also provides constructs to capture determinants (barriers and facilitators) for implementation of innovations in health service delivery and health systems [14]. Given that prescribing MIFE-MISO for T1 MTOP would be a new practice for most Canadian physicians, our Contraception and Abortion Research Team (https://cart-grac.ubc.ca/)[13,14] decided to perform a national study [15], guided by Roger’s theory, to understand health policy, system and service facilitators and barriers to the implementation of mifepristone MTOP practice in primary care. Considering the particular situation of Quebec, CART researchers in Quebec proposed a secondary study where the specific barriers and facilitators of implementation of MIFE-MISO T1 MTOP in Quebec were guided by the theory of the DOI and classified using the TTM.

Methods
This study is embedded in a larger observational mixed-methods programme of research, the CART-Mifepristone Implementation Study (CART-Mife Study) [15]. We (EG & MSW) performed and audiotaped 30–45 min semi-structured interviews in French with family physicians (FP) and obstetricians-gynaecologists (OB) from all Health Regions in Quebec between January and March 2018 (except for one interview in mid-October 2017). Recruitment was performed amongst members of various Quebec medical associations, participants to the quantitative component of the CART-Mife Study, and members of a community of practice for MTOP providers established for the CART-Mife Study (recruitment strategy thoroughly described in a previous publication) [16]. Nurse practitioners were not interviewed because CMQ did not allow them to provide MIFE-MISO without supervision of physicians trained to provide MTOP (Table 1).

The development of the 14-question interview guide [17] was based on Rogers’ theory [13] and its application in training [9,10]. In December 2017, the College of physicians of Quebec (CMQ), the regulatory body for medical practice in Quebec, released its own guidelines, authorising availability of MIFE-MISO in Quebec (one year later than the rest of Canada), with its own restrictions, including mandatory TOP clinical training for physicians not already providing TOP or curettage [11].
organisations [14]. This interview guide allowed us to capture the complex process of implementation of an innovation, on an individual and a system-wide basis. Key constructs such as characteristics of the innovation and the adopter, communication and influence, system antecedents and readiness, outer context and implementation process helped to generate evidence on the facilitators and barriers faced by physicians in adopting the new behaviour.

Confidential transcription of the Quebec interviews took place from April to October 2018 and thematic analysis [18] from October 2018 to March 2019. Through iterative reading, we (EG & MSW) separately organised the data into various themes describing facilitators and barriers; then, we compared our results for each theme and subtheme and resolved discrepancies through discussion to ensure accurate interpretation of the data. In parallel with the thematic analysis, we categorised participants into the five TTM stages defined by the characteristics in Table 2 [12].

Facilitators and barriers were compiled for each stage. In April 2019, we invited participants to answer a 3-question follow-up survey by phone or email regarding: 1) whether or not they had adopted the new behaviour; 2) if they had done so, for how many patients had they provided MIFE-MISO T1 MTOP within the last year; and 3) if they had not started, what was their intention in the future. We calculated percentages and Chi square tests to compare participants started, what was their intention in providing MIFE-MISO in a previous publication [16]. In summary, 81% of participants were females; 46% were 50 years old or older; 43% were working in public TOP clinics; 60% did not provide either T1 MTOP or surgical TOP; and 14% had completed the online MTOP training programme [10].

Baseline behaviour
The classification of participants according to TTM (Table 3) showed that, at the time of interview, only three participants were providing MIFE-MISO (Maintenance stage), and two were about to begin (Action stage). These five participants were already providing both medical and surgical TOPs. All other participants (86%) were either at the Preparation, Contemplation or Pre-Contemplation stages.

Facilitators
As shown with representative quotations in Table 4, at all stages of change, participants were able to identify facilitators to this practice, such as influence or support of colleagues (« … we turned to them [another clinic] to at least have the mechanics and have an idea of how they worked and now it’s sure that it will be available, we’re going to offer it… » (QC-NTNP-18)), requests from patients and colleagues (« … women ask for it because they have heard about it … » (QC-TP-2)), awareness of research and study interest in a new practice. In spite of these facilitators, barriers to implementation were much more often discussed (Table 5).

Barriers
Complexity of local health care organisation
Complexity of local health care organisation (mostly Centres intégrés de santé et de services sociaux which include hospitals and community services in each region) was mentioned by participants in all stages of the TTM. It included lack of administrative will to provide the service, confusion about the qualifications of physicians (FPs versus OB) for provision of MIFE-MISO, possible lack of available physicians because of administrative decisions, time-consuming approval of MIFE-MISO T1 MTOP protocol by multiple decision-making levels, difficulties in obtaining the drug from hospital or community pharmacies, complex drug distribution within the hospital, laborious access to ultrasound dating, serum BvCG or curettage, and difficulties in offering timely first visit and follow-up because of scheduling challenges. As mentioned by one participant: « … We had a plan, but since the announcement of availability in December, I made some contacts with pharmacists in my hospital, I made contacts with my immediate superiors because I work in a health care organisation and, there, it is quite nebulous and not easy and I had an email telling me that no offer of medication should be made as long as we did not have structured directives from a committee that should be set up soon.» (QC-NTNP-18)

Lack of local resources and support of colleagues
Lack of local resources and support of colleagues, and uncertainty about such resources were frequently reported
Table 3. Classification of participants at baseline according to the five stages of change [12].

<table>
<thead>
<tr>
<th>Stages of change</th>
<th>N</th>
<th>Profession</th>
<th>Completed SOGC training</th>
<th>Know of SOGC training</th>
<th>Provision of T1 MA</th>
<th>Provision surgical abortion</th>
<th>Offer MIFE-MISO T1 MA</th>
<th>Intention</th>
<th>Preparation of material</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does offer MIFE-MISO T1 MA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td>3</td>
<td>FP: 3</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Do Not Offer MIFE MISO T1 MA</td>
<td>2</td>
<td>OB: 2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>Ready: 2</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>5</td>
<td>FP: 2</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td></td>
<td>Ongoing: 3</td>
<td>Potential: 2</td>
</tr>
<tr>
<td>Preparation</td>
<td>8</td>
<td>FP: 4</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Contemplation</td>
<td>12</td>
<td>FP: 11</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>Not sure: 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slow Contemplation</td>
<td>12</td>
<td>FP: 11</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>Not sure: 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Contemplation</td>
<td>2</td>
<td>FP: 5</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OB: 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend:
- Profession: Family physician (FP), Obstetrician-gynaecologist (OB).

Table 4. Facilitators according to the five stages of change [12].

<table>
<thead>
<tr>
<th>Facilitators*</th>
<th>Stages of change</th>
<th>Examples of quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influence or support of colleagues</td>
<td>All stages</td>
<td>‘… we met, as a team, so the nurse who is the head nurse at the Centre de consultation des femmes with the managers all that, so we met and we are making prototypes, creating protocols so that it can be done, we wanted that before implementing it that it be really good, that we have a protocol and that the rules of use are clear and, but that’s it, we’re in the process of making protocols…’ (QC-TNP-3) (PREPARATION)</td>
</tr>
<tr>
<td>Request of patients or colleagues</td>
<td>All stages</td>
<td>‘A week or two ago, I death with a family doctor who was approached by a patient, a family doctor who is in X but does not provide abortions, who was approached by a patient because she absolutely wanted this pill and she was approached to know that it was not available at our place. ’ (QC-NTP-17) (PRE-CONTEMPLATION)</td>
</tr>
<tr>
<td>Awareness of research or study</td>
<td>All stages but the slow Contemplation stage</td>
<td>‘… mifepristone, I used it in the context of two or three studies…’ (QC-NTP-16) (MAINTENANCE)</td>
</tr>
<tr>
<td>Interest for a new practice</td>
<td>Maintenance, Action and Slow Contemplation stages</td>
<td>‘… it might also be a reason to change a little bit the way we do things here.’ (QC-NTP-3) (ACTION)</td>
</tr>
</tbody>
</table>

*Facilitators are presented in order of importance, i.e., number of participants mentioning this facilitator. Previous experience is also a facilitator but, in this article, it is treated as a basic characteristic of participants.

by participants in the Preparation and Contemplation stages. Health managers were said to be reluctant to accelerate the process of implementation; participants did not have receptionists and/or counsellors to help them; there were not enough nurses working in their medical clinics (« We only have two and a half nurses working with us (≈ 20 family physicians)… who help doctors make adapted access. So it's not a lot of staff to assist the doctor, answer questions, answer the phone or transfer situations to us that would be problematic. » (QC-NTNP-23)); nurses had precarious working status or were exhausted; FP did not have the support of OB and vice-versa; some participants felt they were left on their own to organise MTOP care; some of their colleagues were against provision of MTOP to preserve existing services; and some OB refused to take care of MTOP complications.

Confusion on practice policies
Confusion and uncertainty about practice policies from the CMQ were mentioned in all stages, and was reported as one of the major barriers at the Action, Preparation and Advanced Contemplation stages. While some participants were unaware of these policies, others were confused, such as this physician: « … what I saw from the Collège des médecins, was that they, in terms of online training, they didn't seem to be too much for that; maybe, I was wrong, they say that it would take doctors who are part of a family planning clinic and who perform [surgical] abortions and who have the expertise in the field to be able to prescribe the abortion pill. However, in my community, there is a doctor [a family physician] who does a lot of obstetrics, and who, for me, with a specific training on this subject, would perhaps be a good person to prescribe the abortion pill…” (QC-NTNP-4). Several participants did not understand who was allowed to prescribe MIFE-MISO. These policies deterred them from providing MTOP, in particular because of the length of the mandatory clinical training. Some participants had the impression that these policies were meant to slow down the implementation of MTOP. Participants felt there were too many regulations regarding this new medication. As one participant expressed: ‘We must not exaggerate the
Table 5. Principal barriers according to the five stages of change [12].

<table>
<thead>
<tr>
<th>Barriers*</th>
<th>Stages of change</th>
<th>Examples of quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complexity of local health care organisation</td>
<td>All stages</td>
<td>‘It’s the big health organisation machine that seems to me to be an obstacle there, because it’s slow, everything is slow, we ask for something there, well we go to a meeting, instead of being every three months, our meetings are every six months because there is no way to plan them, and then when we come back there, nothing has advanced … then, the Minister does not have an umbilical cord with our health organisation, so we do not know … Things are stagnating there, it makes it frustrating.’ (QC-TNP-1) (PREPARATION)</td>
</tr>
<tr>
<td>Lack of local resources or support of colleagues</td>
<td>Preparation, Contemplation (advanced and slow), Pre-Contemplation stages</td>
<td>‘… we have not secretarial services, no services, we are not equipped at our abortion clinic, we have no telephone operator, we have no receptionist to schedule appointments, to do telephone evaluations, because otherwise it is nurses and the social worker who do that, we have no secretary, we have not computer service to transcribe, if there are Excel files to edit, we have no one for us, so that’s an obstacle for us … ’ (QC-NTNP-2) (SLOW CONTEMPLATION)</td>
</tr>
<tr>
<td>Uncertainty/confusion re: practice policies</td>
<td>All stages</td>
<td>‘… I’ve been confused in the last weeks about the information I’ve received from several different involved parties, it means that, yes, it’s actually a barrier there … it would have to be clearer in terms of training, what we really need to do, and you know, clearer in terms of who can really prescribe the abortion pill, is it just doctors of family planning clinics, or if it’s more people, it would have to be clarified … .’ (QC-NTNP-4) (ADVANCED CONTEMPLATION)</td>
</tr>
<tr>
<td>Uncertainty re: collaboration of personnel and colleagues</td>
<td>Preparation, Contemplation (advanced and slow), Pre-Contemplation stages</td>
<td>‘My colleague had been alone at the Family Planning Clinic for five years, and she often asked that there be a gynaecologist from time to time who could come and do abortions, if she was less available or if there were more requests. And the gynaecologist team didn’t want to get on board until now, so I know that she was a little apprehensive about talking to them about [the abortion pill] to see if they were going to get on board or not, since her other attempts in recent years hadn’t been successful … ’ (QC-NTNP-24) (ADVANCED CONTEMPLATION)</td>
</tr>
<tr>
<td>Uncertainty re: lack of information and experience in the practice</td>
<td>Preparation, Contemplation (advanced and slow), Pre-Contemplation stages</td>
<td>‘I have no idea how to deal with [MA] … how do the abortion, the management, the follow-up with the abortion pill … it hasn’t broken through in my environment, so it’s not something that’s easy to start or initiate because we don’t even have the information, it’s not really getting to us … ’ (QC-NTNP-27) (SLOW CONTEMPLATION)</td>
</tr>
<tr>
<td>Abortion services available nearby</td>
<td>Contemplation (advanced and slow), Pre-Contemplation stages</td>
<td>‘What prevents me from giving it is precisely an easy access to people who have an interest in this field and for whom it’s easy … an accessibility that is easy for me. So it’s something that I have than something we don’t have that’s going to keep me from getting into this.’ (QC-NTNP-28) (PRE-CONTEMPLATION)</td>
</tr>
<tr>
<td>Uncertainty re: people involved or could be involved in this practice</td>
<td>Maintenance, Contemplation (advanced and slow), Pre-Contemplation stages</td>
<td>‘Right now, the people I work with are not exhausted, but let’s say they’re aging. So you know, I think the problem we’re going to have eventually if it stays as it is now at the government and management level in relation to doctors’ practices is that we’re going to have a problem eventually to have doctors working on abortions.’ (QC-TP-2) (MAINTENANCE)</td>
</tr>
<tr>
<td>Uncertainty re: organisational flexibility to provide this service</td>
<td>All stages</td>
<td>‘… how do we keep it confidential when we don’t have an abortion clinic and we have a clinic where at the same time as abortion there are also patients who come for all kind of other reasons … and to keep discussions confidential … and consent can be difficult in our communities right now … ’ (QC-TNP-4) (PREPARATION)</td>
</tr>
</tbody>
</table>

*Barriers are presented in order of importance, i.e., number of participants mentioning this barrier.

regulation of it to make it more complicated and thus, it will become inaccessible.’ (QC-NTNP-10)

Other barriers
The availability and close proximity of surgical TOP services was one of the most reported barrier for participants in the Pre-Contemplation stage. Participants in the Slow Contemplation and Pre-Contemplation stages also mentioned lack of information and experience in MTOP practice, low requests for TOP, uncertainty about future practice and ethical concerns. Some physicians, especially those working in TOP clinics, worried about the involvement of primary care professionals and thought that: ‘… many doctors, at least amongst the colleagues we know who do not work in family planning clinics, even if they work a lot in women’s health, they are not used to doing these things [TOPs].’ (QC-TP-2) Another physician also mentioned that it existed: ‘… a culture that was in favour of surgical abortion and that claimed that medical abortion meant bleeding a lot, and hurting a lot … ’ (QC-NTNP-16), and this attitude meant that workers in TOP clinics ‘… weren’t so eager to have access to mifepristone or to offer abortion by medication. We didn’t feel it was a priority’ (QC-NTNP-16) Some physicians expressed concerns because of perceived additional counselling and required reorganisation for clinic functioning: ‘… what raises questions for me is the length of time it takes to explain to the patient … How are we going to get around it with the patient, and the nurses are included in that … ’ (QC-NTNP-15) In addition, a financial impact on the provider income was underlined by some who declared that ‘… some big, big, big surgical abortion clinics probably didn’t like it [MIFE-MISO T1 MTOP] much either … Because there are people whose livelihood depends on doing curettages … ’ (QC-NTNP-3)

Follow-up behaviour
The number of physicians in our sample who provided MIFE-MISO T1 MTOP one year after baseline interviews
Complexity of local health care organisations was the most commonly mentioned barrier to implementation by all participants whatever their stage of change. Such administrative barriers were also seen at the time of MIFE-MISO introduction in England and Wales where some hospital gave low priority to TOP services, and bureaucratic inertia discouraged providers from adopting this new practice [19]. In Australia, where, like Canada, MIFE-MISO was recently approved as a subsidised medicine provided by primary care professionals, institutional capacities, such as lack of a distinct TOP service system, absence of telephone or Internet service to inform patients about TOP facilities and lack of accountability in ensuring local service delivery were reported as key barriers to implementation [20]. Understanding the local context in which implementation takes place is a preliminary step when beginning a new practice; too much perceived local complexity may discourage those with limited motivation [12].

Lack of human and/or material resources, lack of support from colleagues and uncertainty about collaboration, primarily reported by participants in the Preparation and Contemplation stages, echo findings of Doran and Nancarrow [21] as well as those of Furedi of the British Pregnancy Advisory Service stating that staff support is the «absolute single main driver» explaining mifepristone use across providers [19]. As mentioned by participants working in Quebec TOP clinics, difficulties maintaining or recruiting medical staff appeared linked to recent Quebec governmental policy promoting a family physician (FP) for every citizen [22]. This policy requires FP to register at least 500 patients in their clientele and financial incentives are given to register more; therefore, they have limited time or interest to join existing TOP teams or engage in new practices. Similarly, in Australia, the need for partnerships or other collegial arrangements was cited in connection with busy workloads or stigma [20].

As shown in many countries, legal constraints are very influential on access to TOP services [19,23]. Health Canada had removed all restrictions to MIFE-MISO combination use as of April 2019 (Table 1) [9,24]. Yet, the CMQ still requires several of the removed restrictions such as mandatory ultrasound dating, clinical training in TOP before providing MIFE-MISO and no authorisation for nurse practitioners to provide MIFE-MISO in Quebec.
provide MIFE-MISO without physician’s supervision of physicians trained to provide MTOP (Table 1) [11,25]. The CMQ also tightly regulates telemedicine which could otherwise be used in T1 MTOP [26]. Quebec, while being very supportive of TOP access [5], is not the only area in the world where restrictions are notable. In the United States (US), in 2019, where 21 states were hostile or very hostile to TOP rights [27], state policies imposed mandatory delays, need for in-person counselling, mandatory ultrasound, performance of MTOP by a licensed physician only, and prohibition of telemedicine use to provide MTOP [26,27]. Yet, the report of the National Academies of Sciences, Engineering and Medicine of the United States [28], like the publications and guidelines of many leading organisations [29–31], reaffirmed that: T1 MTOP is in the scope of family medicine; it can be provided without ultrasound dating but with appropriate medical history and gynecological examination [32–34]; trained nurse practitioners and physician assistants can provide T1 MTOP as safely and efficiently as physicians [35]; and it can be provided through telemedicine [36,37].

One year after the baseline interview, as predicted by the TTM approach, most participants who were in the Action or Preparation stages started providing T1 MTOP. Interestingly, 90% of them were already working in public TOP clinics. In this regard, they were already aligned with CMQ requirements and thus, had already overcome a major barrier reported by physicians who did not work in such settings. Nevertheless, 44% of participants working in TOP clinics still did not provide MIFE-MISO one year after baseline, illustrating how barriers may exist in a sensitive field monopolised by those who perform surgical TOPs. Communication with the director of the Fédération Québéquoise du planning des naissances, a Quebec feminist organisation monitoring TOP services, indicated that, in April 2019, 23/49 public TOP clinics, mostly located in rural areas, were still not providing MIFE-MISO T1 MTOP [38]. The average number of MIFE-MISO T1 MTOPs provided by our participants did not exceed 27 MTOPs. This low number was corroborated by market shares of MIFE-MISO in Ontario and British Columbia [16]. As shown in a 2017 worldwide review [23], the proportion of all TOPs that were MTOP increased in most countries (proportions up to 59% in France and to 80% to 90% in Sweden and Finland). At the time of mifepristone introduction in Sweden, TOP providers’ receptiveness to provide MTOP depended mostly on the interest of a particular facility’s head and staff [19]. In Great Britain, local medical culture supporting MTOP was also very influential on providers’ uptake of this practice [19]. On the contrary, the pace of increase was slow in Belgium, Germany, Italy and the Netherlands; MTOP represented less than 25% of all TOPs in these countries [23]. In the US [41], 14 years after mifepristone’s approval, 23% of all TOPs were MTOPs. The predominance of surgical TOP in these countries, as in Quebec, was mainly due to restrictive policies, bureaucratic restrictions and preferences among providers or women for surgical TOP [23].

We acknowledge limitations to this study such as a plausible desirability bias and participating in this research being a catalyst to engage in MTOP practice. Since this study was performed at the very beginning of the availability of MIFE-MISO in Quebec, it may have elicited more barriers than facilitators. Our follow-up survey was just designed to capture adoption of the new behaviour one year later and thus, was too brief to describe further facilitators and barriers to the provision of MIFE-MISO. Strengths of our study included a robust sample of 37 participants, representing all Quebec Health regions, through various recruitment strategies, and a theory-informed study and interview guide.

This study highlights several barriers to MIFE-MISO T1 MTOP implementation including additional regulatory restrictions imposed by a provincial jurisdiction, despite strong scientific evidence and Health Canada’s support of its full accessibility in primary care. The province of Quebec is one example where additional regulatory restrictions are imposed by the medical regulatory body [28]. These medical policy restrictions act as a bottleneck to the resolution of other bureaucratic and system barriers. Potential avenues that could improve implementation of MIFE-MISO T1 MTOP in Quebec include enhancing physicians’ and nurse practitioners’ MTOP training, increasing perceived ease of MTOP, emphasising integration of MTOP training in family medicine residency programmes, consolidating surgical TOP clinics with provision of additional services such as treatment of first trimester pregnancy failures, reducing logistical barriers, fostering professional collaboration, and doing research on Quebec women’s attitude towards medical versus surgical TOPs as well as on nurses’ roles, needs and experiences regarding MTOP. Until barriers are addressed and strategies to support uptake of MTOP are implemented, access and choice for individuals in Quebec seeking safe and effective MTOP will continue to be hindered.

Author contributions

WVN, EG, SD and SM developed the study concept and approach with input from all co-authors. SM & ESW developed the codebook with the contribution of EG and M-SW. EG and M-SW did data collection and analysis. EG wrote the first draft of the manuscript. All authors contributed to manuscript revisions and reviewed and approved the final manuscript.

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References


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