ORIGINAL CONTRIBUTION

Acceptability and Feasibility of Early Pregnancy Termination by Mifepristone-Misoprostol

Results of a Large Multicenter Trial in the United States

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Objectives: To evaluate whether the regimen of oral mifepristone and misoprostol for medical abortion is acceptable to women and providers, in the United States, including physicians, nurses, and counselors, and whether proposed modifications of this regimen appear feasible for clinical practice.

Design: A prospective study.

Setting: Seventeen clinics in 15 states.

Participants: A total of 2121 women with pregnancies of 63 days or less in duration.

Interventions: The administration of mifepristone, 600 mg, orally, followed after 2 days by the administration of misoprostol, 400 µg, orally. Clinical observation for 4 hours followed misoprostol administration. Two weeks later, at a checkup, women were questioned about the abortion experience. Providers also answered questions about acceptability and feasibility.

Main Outcome Measures: Patient reports of overall satisfaction with the abortion, the number of women who would choose medical abortion again if needed or recommend the method to others, the best and worst features of the method, and provider and patient assessments of home use.

Results: The regimen was highly acceptable. Nearly all women (95.7%) would recommend it to others, 91.2% would choose it again, and 87.6% found it very or moderately satisfactory. Even among women for whom the method failed, 69.6% would try it again, 84.9% would recommend it to others, and 51.9% found it very or moderately satisfactory. The chance to avoid a surgical procedure was reported as the method's best feature. The most commonly cited worst features were the uncertainty and fear of side effects. Providers and women considered home use feasible and safe.

Conclusions: American women found abortion with the use of mifepristone and misoprostol acceptable. Even most with unsuccessful outcomes would select the regimen again and recommend it to others. Most providers and women thought that home use of misoprostol should be available for women who prefer it.

Arch Fam Med. 1998;7:360-366

MEDICAL abortion promises a new nonsurgical option to women seeking early pregnancy termination. Indeed, the combination regimens of mifepristone-misoprostol and of mifepristone-gemeprost for early abortion are established as safe, effective, and acceptable to women and health care providers in Europe and in several developing countries.[1,2] In the United States, however, medical methods have, until recently, seldom been used. By granting mifepristone, also known as RU 486, "approvable" status in 1996, the Food and Drug Administration cleared the major regulatory hurdle for the introduction of a labeled oral abortifacient in this country. In anticipation of the widespread introduction in the United States of mifepristone-misoprostol for medical abortion, our large multicenter clinical trial conducted in the United States aimed to answer 3 questions: (1) How well does the French mifepristone-misoprostol regimen work in women with pregnancy durations of 63 days or less since the last menstrual period? (2) Is an oral regimen of early medical abortion acceptable to American women? and (3) Is the use of the regimen feasible in the American medical system? The first question is addressed elsewhere.[3] The last 2 are answered here.

For a new technology to be a viable option in a given health care system, even in a free service, people need to want to use it and to demand it. For this reason, understanding how potential patients perceive and value a new technology is im-

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SUBJECTS AND METHODS

Participants, exclusion criteria, and survey methods are described in detail elsewhere.[3] The study was approved by the Institutional Review Board of the Population Council, New York, NY, and local institutional review boards. All study sites followed a uniform protocol.

A total of 2121 women participated at 17 clinics in a trial that ran from September 13, 1994, to September 12, 1995. The sites represented several health care environments, including Planned Parenthood affiliates, university hospitals, and freestanding clinics (private physicians' offices and feminist health centers), and although most principal investigators at these sites were obstetrician-gynecologists, there were several family physicians and 1 osteopathic physician. Patients followed the oral regimen of mifepristone-misoprostol that is standard in France. Women with pregnancy durations of 63 days or less (as assessed by a combination of menstrual history, pelvic examination, and vaginal ultrasonography) ingested mifepristone, 600 mg, at their first clinic visit. Two days later, they received misoprostol, 400 µg, orally, and were observed for 4 hours. At a final visit 12 days later, each patient's pregnancy status was assessed, and patients answered several questions about acceptability. Women rated the abortion experience overall, compared it with previous abortions (where applicable), and indicated whether they would use the method again or recommend it to others. They also noted whether they would feel comfortable taking mifepristone or misoprostol at home. As part of an investigator's questionnaire, providers assessed the potential for the safe home use of mifepristone-misoprostol. All abortion-related medical care was free to eligible women who chose to participate in the trial.

Descriptive statistical techniques and χ^2 analyses were used. Comparisons were designated as significant at $P \leq .05$. All statistical analysis was performed using commercially available software (Statistical Package for the Social Sciences, SPSS Inc, Chicago, Ill).

portant. In the case of medical abortion, however, patient acceptability is key to the success of the method. Indeed, surgical intervention rates (*failures* under our definition) are influenced by patients' attitudes, expectations, and tolerance of side effects and by providers', including physicians, nurses, and counselors, understanding and aptitude for using the method.[4] For medical methods of abortion to work successfully, women must commit to completing the regimen, and both women and providers must wait while the therapy takes its course.

Despite the potential for patient acceptability to influence medical abortion success rates, the North American literature on the acceptability of early medical abortion is scant.[1] A regimen of methotrexate-misoprostol was found acceptable by a sample of women (N = 285) with gestations of 56 days or less[5] in the United States and by a larger cohort (N = 352) in Canada with shorter gestations.[6] Another

Table 1. Characteristics of 2121 Patients and Type of Clinic by Efficacy Outcome*

Patient and Clinic Characteristic	Efficacy Outcome, %		
	Success	Failure	Total
Ethnicity	(n = 1720)	(n = 295)	(n = 2015)
African American	85.1	14.9	14.3
Asian	91.7	8.3	4.2
White	85.3	14.7	70.9
Hispanic	82.5	17.5	8.8
Other	89.2	10.8	1.8
Gestational age, d†	(n = 1720)	(n = 295)	(n = 2015)
≤49	92.1	7.9	41.0
50-56	83.0	17.0	33.6
57-63	77.5	22.5	25.3
Method of payment that would have been used if study abortion were not free	(n = 1695)	(n = 291)	(n = 1986)
Self-pay	86.4	13.6	73.6
Insurance or HMO	83.3	16.7	15.4
Medicaid	80.2	19.8	5.6
Other financial assistance	82.4	17.6	5.4
Type of facility	(n = 1720)	(n = 295)	(n = 2015)
University hospitals	85.2	14.8	25.6
Planned Parenthood affiliate	86.0	14.0	43.5
Freestanding clinics	84.6	15.4	30.9

**The total numbers in the table differ from the total study sample size because 106 women did not return for their final study visit and an additional 29 did not answer the question about method of payment. HMO indicates health maintenance organization.*

†P<.001.

trial found a regimen of oral mifepristone, 200 mg, plus vaginal misoprostol, 800 µg, acceptable to 166 women with pregnancy durations of 56 days or less from their last menstrual period.[7] Although all of these studies suggest that North American women find medical abortion acceptable and desirable, a thorough investigation of the method's acceptability and feasibility among women at a variety of health care settings across the United States is in order.

RESULTS

EFFICACY AND SAFETY

Because surgical methods are already standard practice in the United States, the goal of medical abortion is to help women avoid a surgical procedure for abortion. We defined *failure* to mean that a woman was unable to avoid an operation for her abortion.[4] Women received surgical interventions when requested, when the drugs failed to terminate the pregnancy completely, when women did not want to wait for the medical abortion to occur, or when intervention appeared medically necessary. Occasionally, women had surgical interventions that, in hindsight, appeared unnecessary. In each case designated as a failure, however, the medical method failed to allow the woman to avoid surgical intervention.

Success rates in the trial varied by gestational age (**Table 1**). Among women with pregnancies of 49 days or less since their last menstrual period, 92.1% had successful medical abortions. These results are similar to the French experience.[8] Among those with pregnancy du-

Table 2. Reasons 2121 Women Gave for Choosing the Medical Method of Abortion*

Reason	Total, %†
No surgery and/or injections, noninvasive, fear of surgery and/or injections	37.4
Natural, more "feminine," like menses or miscarriage	19.4
Study features: free, no insurance questions, good medical care	17.3
Safer, fewer side effects or risks of complication	12.0
Support US use, choice for women	10.7
Previous (recent, unpleasant) surgical abortion	10.2
Easier, simpler, faster	10.1
Method recommended, heard good things about it	7.9
Less pain, cramping	7.5
Easier emotionally, less frightening or traumatic	7.0
Seemed better	5.1
Can be done earlier	4.5
Less humiliating, more humane	4.4
Intrigued, curious	3.7

*Only reasons cited by more than 3% of respondents are shown.
†Sums to more than 100% because more than 1 reason may be given.

rations of 50 to 56 days and 57 to 63 days, the success rates were 83.0% and 77.5%, respectively. Efficacy did not vary significantly by type of facility.

Side effects also affect acceptability. Serious side effects were rare. Four women received blood transfusions after heavy bleeding. Other side effects, however, were far more frequent. The most prevalent side effects were similar to those experienced with spontaneous abortion: cramping and bleeding. Many women also had gastrointestinal side effects, particularly nausea (67.3%), vomiting (33.9%), and diarrhea (22.9%). About a third of the women (32.1%) reported headache, and 12.2% reported dizziness.

ACCEPTABILITY

Reasons for Selecting Medical Abortion

At enrollment, women were asked why they opted for mifepristone-misoprostol treatment. Women gave as many as 5 reasons. More than half of the women offered more than 1 reason for choosing medical abortion. Only 1.8% did not offer any reasons or were unsure of the reason for their choice. The most frequently cited category of reasons, offered by 37.4% of the women, was that the regimen allowed them to avoid an operation or injections (or both) and was not invasive (**Table 2**). Nearly a fifth (19.4%) selected the method because it seemed natural, or "feminine," like a miscarriage or menses. Some women (17.3%) pointed to desirable study features, such as the quality of the staff involved in the trial, the absence of insurance questions, or that the treatment was free. Women also cited the method's safety and low risk of complications and side effects (12.0%) and a political commitment to abortion rights and the availability of mifepristone in the United States (10.7%). Precisely 10.2% said that they chose medical abortion because they had previously had a surgical abortion. Some women elaborated that their previous surgical abortion had been particularly unpleasant or recent. Finally, 10.1% reported that they chose the medical method because it seemed easier, simpler, or faster.

Table 3. Topics That Could Have Been Better Explained to 87 Women Who Felt the Explanation Provided Had Been Inadequate*

Topic	Women, No. (%)†
Severity, duration of nonbleeding adverse effects	31 (36)
Wanted more of the information to be given at first visit	13 (15)
Amount of bleeding, clots	13 (15)
Length of bleeding	9 (10)
High probability that side effects could occur	8 (9)
Possibility of 2-wk abortion process	6 (7)
Similarity to miscarriage	5 (6)
Possibility of complications	5 (6)
Action of drugs on body	4 (5)
Recognizing a complete medical abortion	4 (5)

*Only answers cited by more than 3% of respondents are shown.
†Sums to more than 100% because more than 1 reason may be given.

Adequacy of Explanations of Treatment

At their first visit, patients were counseled about what to expect. At their exit visit, they assessed whether the experience had been adequately explained. Nearly all of the women (95.6%) felt that the explanations given were adequate. Among women for whom the method failed, slightly fewer (93.0%) considered the explanations adequate. The effect of failure on the reported adequacy of explanation was statistically significant (Pearson χ^2, $P = .02$). Of the 87 women who said their explanations had not been adequate, 75 (86%) further described a deficiency of their explanation (**Table 3**). Although women could report as many shortcomings as they wished, only 19 (22%) of these women cited 2 or more topics. The main issues mentioned were severity and duration of nonbleeding side effects (31 [36%]), a need for more of the information to be provided at the first visit (13 [15%]), the amount of bleeding and clots (13 [15%]), and the length of bleeding (9 [10%]).

Divergence From Expectations

Although nearly all women thought the method had been adequately explained, 48.6% stated at the trial's end that their experience had differed from what they had expected. Patients who received surgical interventions (ie, method failures) (n = 295) were significantly more likely (65.2%) than women for whom the method worked (46.0%) (n = 1720) to report a divergence (Pearson χ^2, $P<.001$). Among those women whose experiences differed from expectations (n = 952), about two thirds (61.9%) felt the experience was better than anticipated, but about a third (34.5%) thought it worse than expected. Not surprisingly, in the subset of women who reported a mismatch between expectations and experiences, successful users were more likely than others to classify the experience as better than expected (71.2% vs 20.1%). Conversely, women for whom the method failed were more likely than others to report that the experience was worse than expected (70.1% vs 26.5%).

Table 4. Divergence From Expectation of Experience by Efficacy Outcome

Expectation	Efficacy Outcome, %		
	Success	Failure	Total
Duration of bleeding*	(n = 1701)	(n = 261)	(n = 1962)
Longer	42.5	39.1	42.0
As expected	38.8	23.8	36.8
Shorter	14.6	25.7	16.1
Not sure	4.1	11.5	5.0
Amount of bleeding*	(n = 1703)	(n = 262)	(n = 1965)
More	37.3	42.0	37.9
As expected	42.5	20.2	39.5
Less	17.3	28.2	18.7
Not sure	3.0	9.5	3.9
Amount of pain*	(n = 1701)	(n = 256)	(n = 1957)
More	18.7	25.0	19.5
As expected	29.3	27.7	29.1
Less	49.0	36.7	47.4
Not sure	3.0	10.5	4.0
Overall experience*	(n = 1691)	(n = 267)	(n = 1958)
Worse than expected	12.2	45.7	16.8
As expected	54.0	34.8	51.4
Better than expected	32.8	13.1	30.1
Different but unspecified	1.1	6.4	1.8

*P<.001.

Because bleeding and pain are nearly universal side effects, women were questioned specifically about their expectations and experiences with these events (**Table 4**). About a third of women said that the duration and amount of bleeding, as well as the amount of pain, matched their expectations. Nearly half (47.4%) reported less pain than expected. Successful users were marginally more likely to say that their experiences were as expected. The distribution of responses differed significantly (Pearson χ^2, $P<.001$) for each variable according to whether the method had failed or succeeded.

Comparison With Previous Abortion

Half of the women (49.5%) had previously had a surgical abortion. These 1049 women were asked to compare the medical abortion experience with their previous abortion (**Table 5**). Three quarters (76.9%) rated the study abortion as more satisfactory, 13.0% said that it was just as satisfactory, and 10.1% said it was less satisfactory than the previous abortion. Unsuccessful users were significantly less likely (Pearson χ^2, $P<.001$) than others to rate the medical abortion as more satisfactory than the previous abortion. Even among patients who had method failures, however, 44.6% felt the failed medical abortion had been more satisfactory than the previous surgical abortion, although 36.9% thought the experience was less satisfactory than their previous surgical abortion. By contrast, only 5.4% of the women for whom the medical method succeeded considered the study abortion less satisfactory than their previous surgical procedure.

Overall Satisfaction With the Abortion

At the exit visit, women ranked their overall satisfaction with the use of mifepristone-misoprostol on a 5-point scale

Table 5. Measures of Satisfaction by Efficacy Outcome

Measure of Satisfaction	Efficacy Outcome, %		
	Success	Failure	Total
Overall satisfaction*	(n = 1694)	(n = 264)	(n = 1958)
Very satisfactory	78.7	32.2	72.5
Moderately satisfactory	14.4	19.7	15.1
Fair	5.3	17.0	6.8
Moderately unsatisfactory	0.9	9.5	2.0
Very unsatisfactory	0.7	21.6	3.5
Satisfaction compared with previous abortion*	(n = 892)	(n = 157)	(n = 1049)
More satisfactory	82.6	44.6	76.9
Less satisfactory	5.4	36.9	10.1
Just as satisfactory	12.0	18.5	13.0
Would choose again*	(n = 1679)	(n = 263)	(n = 1942)
Yes	95.3	69.6	91.8
No	4.7	30.4	8.2
Would recommend to friend*	(n = 1684)	(n = 2654)	(n = 1949)
Yes	97.4	84.9	95.7
No	2.6	15.1	4.3

*P<.001.

that ranged from "very satisfactory" to "very unsatisfactory" (Table 5). Precisely 87.6% ranked the experience as very or moderately satisfactory. Patients for whom the method failed were less likely than others to rank the medical regimen as very or moderately satisfactory, although 51.9% still gave these ratings. Women for whom the method failed were more inclined than successful users to classify the experience as very unsatisfactory (21.6% vs 0.7%). The gestational age category was not significantly related to the assessment of satisfaction for either successful or unsuccessful users ($P = .36$ for successful users and $P = .06$ for unsuccessful users). Among women for whom the method failed, however, those with pregnancies of 49 days' duration or less recorded significantly higher satisfaction than did others.

Other Measures of Satisfaction

Women reported whether they would choose the method again (if needed) or recommend it to friends. In both respects, mifepristone-misoprostol use won nearly universal approval: 91.8% would select the method again, and 95.7% would recommend it to a friend or relative. Women having failures gave lower ratings than did others, but even these women strongly endorsed the method: 69.6% would choose to use mifepristone-misoprostol again vs 95.3% of successful users, and 84.9% would recommend the method to others (vs 97.4% of successful users).

Best and Worst Features of the Method

At the final visit, women were asked to describe the best and worst features of the method. Women cited as many open-ended features as they wished. Patients offered considerably more best (3388 features) than worst features (2164 features). More than half (55.1%) offered at least 2 best features, and 32.2% cited at least 2 worst features (**Table 6**). The most commonly cited positive attributes were no surgery and/or injections, noninvasive

Table 6. Best and Worst Features of Medical Abortion Method (n = 1988)*

	% of Women†
Best Features	
No surgery and/or injections, noninvasive, no fear of surgery or injections	45.1
Natural, more "feminine," like menses or miscarriage	23.6
Less pain, cramping	19.8
Easier emotionally, less frightening or traumatic	16.9
Easier, simpler, faster	9.7
Privacy, being at home	8.4
Healthier, fewer side effects	7.3
Safer, fewer risks of complications	6.3
Less humiliating, more humane	6.0
Good medical attention, group support	5.8
Avoids anesthesia	5.1
Have control, do it yourself	4.3
Convenient, more compatible with other duties	3.1
None, not sure	5.0
Worst Features	
Pain, cramping (feared or actual)	22.5
Waiting, uncertainty, fear of unknown	13.9
Nausea, vomiting, diarrhea (feared or experienced)	10.8
Amount of bleeding or clots	8.4
Takes too long	8.1
Too many long visits	7.7
Length of bleeding	6.9
Method failed, not 100% effective	6.3
Bleeding, unspecified	5.3
Other side effects (feared or experienced)	4.2
Seeing embryo	3.7
None, not sure	22.0

*Only answers cited by more than 3% of respondents are shown.
†Sums to more than 100% because more than 1 feature may be given.

(45.1%); natural, "feminine," like menses or miscarriage (23.6%); less pain (19.8%); easier emotionally, less frightening (16.9%); and easier, simpler, or faster (9.7%).

The most commonly cited worst features frequently related to feared as well as actual difficulties: many women did not distinguish between feared and actual side effects. Feared or actual pain or cramping (22.5%); waiting, uncertainty, or fear of the unknown (13.9%); and feared or actual nausea, vomiting, or diarrhea (10.8%) were the most commonly cited worst features of mifepristone-misoprostol abortion. On the other hand, 22.0% of the women said that there had been no worst features at all. Women rarely cited the messiness of the bleeding (<3%) or the sight of the embryo (3.7%) as worst features.

FEASIBILITY

Whether a new method of clinical care comes into widespread use depends on its acceptability to patients and providers and on characteristics of the method and of the medical care system. Women were asked to assess the difficulties posed by various aspects of the regimen.

Problems With Time or Place of Abortion

One area of possible concern is that women must cope with both the inconvenience and uncertainty about the time or place that the products of conception may be expelled. In fact, because women were asked to wait 4 hours in the clinic after ingesting misoprostol, most successful medical abortions (67.6%) occurred there, according to women's recollections at the exit visit. On the other hand, many successful medical abortions reportedly took place at home (21.9%), en route to or from the clinic (1.2%), or elsewhere (3.7%). Almost six percent (5.7%) of women with complete abortions could not identify the location.

The time and place of the expulsion troubled few women (3.8%) with successful abortions. Clinic and home expulsions rarely posed problems. Only 17 (1.5%) of the women with successful abortions who aborted in the clinic (n = 1134) considered the time or place a problem, and 16 (4.3%) of those aborting at home (n = 370) felt similarly. By contrast, expulsions that occurred elsewhere were problematic for 12 (60%) of the 20 women who had their expulsions while traveling to or from the clinic, as well as for 15 (25%) of those who had their expulsions at other unspecified locations (n = 61).

Scheduling Difficulties

The mifepristone-misoprostol regimen currently requires 3 clinic visits. Although the need for 3 visits was explained during recruitment and reemphasized during counseling, 5.0% of women did not return for their third visit. Providers contacted these women by telephone, and when this proved unsuccessful, they attempted to reach them by mail as well. Among the 2015 women who returned for their third visit, 21.9% reported difficulty scheduling the 3 required visits. Most difficulties arose from the need to juggle complex schedules. Among women reporting trouble scheduling the visits, work commitments (47.6%), transportation (14.9%), school obligations (13.5%), and child-care needs (11.4%) were the most frequently cited reasons.

Potential Use of Mifepristone-Misoprostol Outside the Clinic

The final feasibility questions pertained to the possible use of the regimen's 2 drugs by women in their homes. Each woman was asked whether she would feel comfortable taking each of the 2 drugs at home. Investigators also assessed, at each patient's discharge interview, whether the self-administration of each drug at home would have been safe, based on her clinical course. Both women and providers endorsed the feasibility of home administration of both medications. Prospects of taking mifepristone itself at home daunted few patients and even fewer providers. Only 8.3% of women's responses and 1.0% of provider assessments held that mifepristone use at home would have been uncomfortable or unwise for a given patient. Interestingly, preliminary analysis suggests that ethnic groups differ in their comfort with home use of mifepristone ($P<.001$). Hispanic and Asian women were significantly less likely than other women to feel comfortable taking mifepristone at home. Providers' ratings of the safety of self-administration were less positive for Hispanic than for other women ($P<.01$).

The home administration of misoprostol, however, raised more questions in the minds of patients and clini-

cians. Still, the majority of both groups were comfortable with the idea of use at home. There was no effect of gestational age on women's comfort with the home use of misoprostol. Two thirds (65.2%) of women said they would feel comfortable taking misoprostol at home, and clinicians noted that 85.5% of the women would safely have been able to use the misoprostol at home. This latter figure may be misleading, however, because clinicians varied widely in their propensity to report that the home use of misoprostol would be safe. One investigator ranked 99.5% of patients' experiences as incompatible with safe home use. If that outlier is deleted, the proportion of patients assessed by clinicians as safely able to use misoprostol at home rises to more than 94.5%. In 5 clinics, more than 98% were deemed to have been good candidates for the safe home use of misoprostol. Clinicians judged the self-administration of misoprostol as feasible more often among white ($P<.01$) and African American ($P<.001$) women and less frequently among Hispanic women ($P<.001$). Asian and Hispanic women ($P<.05$ for both) were also more likely to report that they would be uncomfortable with the idea of self-administration. Providers at Planned Parenthood affiliates (91.6%) and freestanding clinics (97.8%) were significantly more likely than those at university-based hospitals (69.5%) to judge the home use of misoprostol as safe ($P<.001$) for both successful and unsuccessful users. Women themselves did not differ significantly in their assessments by the type of facility.

COMMENT

A medical abortion regimen of mifepristone and misoprostol is a highly acceptable alternative in the United States. Our trial results accord with previous research findings that early medical abortion is desirable to the women who choose it.[6,9,10] Despite socioeconomic, cultural, or political differences, views of the participants in this trial resonate with those of women living in various regions of the world. Indeed, much as in previous medical abortion acceptability studies conducted in other parts of the world, when asked why they had chosen medical abortion, women in this study assigned great importance to avoiding invasive surgical procedures and to an experiential quality of the method that women consider natural.[1]

Most women, regardless of several differences in background, endorsed the method. Even a remarkable proportion of women for whom the method failed still rated it highly. More than 30% of them reported that the method was very satisfactory, whereas fewer than a quarter found the experience very unsatisfactory. In assessing the method's acceptability, many women who gave modest ratings to the study abortion itself were willing to try the method again if needed and were more willing still to recommend it to others. This finding has methodological implications for future research into acceptability. Women's assessments of their specific experiences do not preclude an even more positive rating of a method's use in the future or a recommendation of the procedure to others.

Study data also suggest that the option of a less medically supervised regimen may be feasible and desirable. Nearly all providers thought that most women could safely have used the method at home. Women felt similarly, although they were less comfortable with the prospect of taking misoprostol at home than mifepristone. Specific counseling about what to expect in the hours after the self-administration of misoprostol and the availability of a 24-hour telephone support line may help allay women's concerns. Indeed, preliminary results[7] from an ongoing multisite study allowing home administration of misoprostol indicate that women find this option highly acceptable as well. Because some women would prefer to have their medical abortions in the clinic, women should ideally have a choice over the degree of medical supervision involved.[11]

Although providers commented on the clinical course of each woman participating in this study, more information on providers' attitudes toward medical abortion would be valuable. The results of focus groups conducted with providers from this study show that generally they liked offering women a choice of methods and that even those who were initially skeptical about medical abortion grew to like the method. Indeed, by the end of the study, 48 (62%) of the 78 providers in the focus groups reported that they would choose mifepristone medical abortion themselves if needed.[12]

CONCLUSIONS

American women find the highly effective mifepristone-misoprostol regimen acceptable. Even a large percentage of women for whom the method failed said that they would try it again if needed and that they would recommend it to a friend or relative. Providers in the American health care system also appeared favorable toward the method and seemed to consider the technology feasible for women in this country.

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Accepted for publication March 23, 1998.

This research was funded by the Population Council, New York, NY.

We thank our colleagues Ann Robbins, PhD, Lauri Benton, MD, Irving Spitz, MD, and Wayne Bardin, MD.

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